SCOTTISH HOSPITALS INQUIRY

Witness Statement of
Michael Baxter ("Mike Baxter")

20 April 2022

Professional background

1. I am Mike Baxter, aged 55 years. My address for the purposes of this inquiry is c/o Harper Macleod LLP, 65 Haymarket Terrace, Edinburgh, EH12 5HD. I have been a qualified accountant since 1992, having qualified through the Chartered Institute of Public Finance and Accountancy (CIPFA). I also hold a BA (Hons) degree in business studies.

2. I am currently Director of Finance and Corporate Services at the Scottish Qualifications Authority (SQA). I previously held the role of Scottish Government Deputy Director (Capital Planning and Asset Management) within the Health and Social Care Directorates, having been appointed to that role on 16 February 2009, following the retirement of my predecessor in that role, David Hastie. I held the role of Deputy Director until end of December 2014, when I left to take up the role of Director of Finance (and subsequently Finance and Corporate Services) at Transport Scotland, an Executive Agency of the Scottish Government. I took up my appointment at the SQA on 6 January 2020. I am accordingly making this witness statement in my personal capacity.

3. During the period of my tenure as Deputy Director, I chaired the Scottish Government Capital Investment Group ("CIG") and in that role I had responsibility for the Scottish Government's infrastructure investment policy for the area of health and social care. That role included: -

    - Allocating and managing the capital resources made available to NHSScotland to invest in modern, fit for purpose assets.

- Oversight of business case and approval processes and monitoring the delivery of major investment projects developed by NHSScotland Boards (time and cost).

- Providing appropriate guidance to NHSScotland in relation to the above.

- Leading input to Government Spending Reviews and annual budget cycles for health infrastructure.

- Providing the policy context to support the strategic planning, acquisition, management and the efficient disposal of physical assets required to support the delivery of healthcare services by NHSScotland.

- Supporting the efficient delivery of capital investment through the development and implementation of effective and efficient procurement approaches.

- Establishing arrangements to support collaborative procurement of imaging equipment across NHSScotland.

- Supporting the development and delivery of major capital projects including those being developed through private finance, such as Non-Profit Distributing Model ("NPD"), a Scottish derivative of Public Private Partnership ("PPP").

- Providing advice internally to those within Scottish Government Health and Social Care Directorate ("SGHSCD"), Ministers and those on NHS boards on capital investment, asset management and related issues.

4. Prior to taking up the role of Deputy Director (Capital Planning and Asset Management), I held the role of Head of the Private Finance and Capital Unit within the SGHSCD from August 2002. I was in charge of the capital budget for the NHS and private finance policy and was a member of the CIG. Key responsibilities included:

- Preparing, allocating and monitoring the capital budget for the Health Directorates and NHSScotland.

- Leading on the development of Spending Review capital investment strategy input for health.

- Reviewing and approving capital investment plans within Local Delivery Plans.

- Development of appropriate procurement methodologies to support capital investment.

- Providing direct advice to Ministers and Senior Officers on capital and Public Private Partnerships ("PPP") related matters as they affect Health.

- Providing advice and support to NHSScotland in their development of infrastructure investment proposals and procurement in accordance with the Scottish Capital Investment Manual ("SCIM") https://www.pcpd.scot.nhs.uk/Capital/scimpilot.htm (Bundle 3, vol.2, doc 33, p.120).

- Developing and updating appropriate guidance in support of infrastructure investment.

- Reviewing Business Cases for Infrastructure investment and providing advice to the CIG on capital related matters.

5. My colleague, Norman Kinnear, was heavily involved at the earlier stages of both the RHCYP/DCN and QEUH projects. He was our PPP Facilitator and Major Capital Projects Advisor. He left Scottish Government in around December 2011 and sadly passed away a number of years ago. Norman used to attend Project Board meetings for all major investment projects including those in Edinburgh and Glasgow. When Norman became ill I started attending those in an observer capacity, however, cannot recollect specific dates. Scottish Government representatives attended project board meetings in an observer capacity given their roles in the approval of projects as members of the CIG.

Overview

6. In this statement I will address the undernoted themes: -

a. The Scottish Government Health and Social Care Directorates ("SGHSC")
b. The Scottish Public Finance Manual, the SCIM and Policy on Design Quality for NHSScotland
c. SGHSC Capital Investment Group
d. SGHSC Capital Investment Group – Business Case Review Process
e. SGHSC Capital Investment Group – Business Case Scrutiny
f. The need for a new hospital
g. Governance and Decision Making
h. Site constraints and contractual issues with Consort
i. Switch to the Non Profit Distributing ("NPD") model
j. Reference Design
k. Design Assurance
l. Health Facilities Scotland
m. SHTMs
n. Chief Executive Letters
o. Status of other relevant guidance
p. Decision to design the RHCYP/DCN to include multi-bed rooms
q. Answers to questions posed in the Rule 8 request dated 10 February 2022

The Scottish Government Health and Social Care Directorates

7. SGHSCD is a group of 13 Scottish Government Directorates responsible for the NHS in Scotland. Each directorate has responsibility for a different function relative to NHS' delivery of health and social care in Scotland.

8. I was the Deputy Director (Capital Planning and Asset Management) within the Health Finance Directorate (now called the Directorate for Health Finance, Corporate Governance and Value), between February 2009 and December 2014, which covered the period of interest to the Inquiry. The Director at that time was Mr John Matheson, who was Director of Finance and Information within SGHSCD. My team was responsible for

Health Infrastructure, Investment and Public Private Partnerships, as they applied to NHSScotland.

9. As I explain more fully below, all relevant business cases in relation to healthcare capital projects in excess of NHS Board delegated limits were considered by CIG, which is contained within Annex C of CEL 32 (2010) (Bundle 4, doc 11, p.146), which I chaired in my role as Deputy Director and, which included my team in conjunction with colleagues from across Health and Social Care Directorates. Health boards are reliant upon funding approval from the Scottish Government. If the Scottish Government does not approve the business case then the capital project under contemplation will not be developed/ delivered.

The Scottish Public Finance Manual, Scottish Capital Investment Manual and Policy on Design Quality for NHSScotland

10. The Scottish Public Finance Manual ("SPFM") https://www.gov.scot/publications/scottish-public-finance-manual/background-and-applicability/background-and-applicability/ is issued by the Scottish Ministers to provide guidance to the Scottish Government and other relevant bodies on the proper handling and reporting of public funds.

11. The Scottish Ministers have also issued related guidance that is sector specific. SCIM provides guidance on the processes and techniques to be applied in the development of all infrastructure and investment programmes and projects within NHSScotland. The guidance applies to the process of project development from inception to post project evaluation. SCIM gives guidance on issues around investment appraisal, financial (capital and revenue) affordability and procurement, project management and governance arrangements required to support the development of programmes and projects.

12. SCIM is also linked to the "Policy on Design Quality for NHSScotland" issued under cover of HDL (2006) 58 on 23 October 2006 (Bundle 3, vol.1, doc 4, p.113) and which has been superseded by the updated policy issued under cover of CEL 19 (2010) on 2

June 2010 (Bundle 4, doc 9, p.99). This policy explicitly sets out at Annex A of the 2010 policy the mandatory requirements on health boards including the requirement to use the Activity Database ("ADB") developed by the Department of Health in England aligned to the relevant technical guidance. This was set out as mandatory requirement 5 of the 2006 policy and mandatory requirement 7 of the 2010 updated policy. The 2010 policy advises at Annex B that ADB is mandatory and that while based on Department of Health guidance in England care should be taken to ensure that outputs are consistent with the technical guidance produced by Health Facilities Scotland ("HFS").

13. The principles set out in SCIM and the Policy on Design Quality are applicable to all health boards in relation to the development of all infrastructure and investment schemes regardless of their size or complexity. These are designed to provide an audit trial and assurances that appropriate steps have been followed in the investment decision making process. Both SCIM and the policy should have been applicable during the business case and approval process for the Royal Hospital for Children and Young People ("RHCYP") and the Department of Clinical Neurosciences ("DCN") (together "the Project"),. The 2010 Design Policy introduced the NHSScotland Design Assessment Process ("NDAP") as an integral part of the SCIM and therefore the assessment of business cases. I have been asked if NDAP applied to the Project considering the timings of the various business cases. I cannot recall the details of this given the timing of the Policy on Design Quality and the approval of the various business cases, however, paragraph 1.70 of the Outline Business Case ("OBC") in relation to the Project submitted to CIG in 2012 refers to a range of processes undertaken prior to the OBC receiving approval. I would therefore assume that NDAP or equivalent processes had been applied.

14. All health infrastructure business cases submitted for consideration will be assessed against the guidance contained within the SCIM. If the business cases are non-compliant with the guidance they would not be approved without required revision/ amendment.

SGHSC Capital Investment Group

15. Up until 12 September 2019, CIG was responsible for approving, within defined limits as per Annex C of CEL 32 (2010), up to £5 million or recommending approval to Director

of Finance up to £10 million or DG Health and Social Care in excess of £10 million and monitoring the delivery of major capital investment projects developed by health boards (regardless of the ultimate funding route adopted by the procuring organisation)[1]. Aside from the subsequent updating of the delegated limits, as far as I am aware, the purpose of CIG and the business case approval process applicable to the Project remains applicable today. CIG is constituted by the following Directorates/Divisions/Branches of Scottish Government: Health Finance – Capital, Directorate of Delivery and Performance, Analytical Services (Economics), Health Finance, Information Management and Technology, Chief Medical Officer Directorate, Joint Improvement Team and the Chief Dental Officer. I was the chair of CIG between February 2009 and December 2014, when I then left Scottish Government Health and Social Care Directorates. CIG receives advice and support on planning, procurement, construction and facilities management issues from NHS National Services for Scotland ("NHS NSS") and the Scottish Futures Trust. CIG will also obtain advice from relevant clinical and policy colleagues where appropriate depending on the nature of the services to be provided from the facilities in question.

16. By approving (or by recommending approval subsequently granted) the business cases submitted to it, CIG gives health boards the assurance of SGHSC support for the strategic justification for progressing capital schemes whilst sending a clear indication to the private sector of the projects which are supported by SGHSC.

17. CIG also plays a vital role in providing the necessary assurances to both Scottish Ministers and SGHSC Management Board that proposals are robust, affordable and deliverable.

18. The CIG also acts as a forum for the development, promotion and distribution of best practice and guidance within capital planning and development whilst providing the SGHSC with an overview of the strategic direction of NHSScotland.

[1] The CEL (32) 2010 (Bundle 4, doc 11, p.146) had graduated delegated limits. The delegated limits for NHS Lothian and Glasgow were set at £5m – See Appendix C of the CEL. These limits were updated on 15 September 2019 by DL (2019) 5.

19. As I mention at paragraph 15, within the SGHSC for projects above Board delegated limits, the Chair of CIG has delegated authority to approve projects with a capital cost of up to £5 million. For projects between £5 million and £10 million CIG will, following the successful consideration of a Business Case, make a recommendation for approval to SGHSC Director of Finance and Information[2] who has delegated authority to approve. In the case of schemes with a capital cost in excess of £10 million CIG will make a recommendation to the Director General Health and Social Care. The RHCYP/DCN received a positive recommendation, and the Chief Executive of NHS Lothian would have been notified of this by DG Health and Social Care.

SGHSC Capital Investment Group – Business Case Review Process

20. I understand that the Inquiry, at this time, is not focussed on the detail of the particular business case reviews undertaken for the Project, so at this stage I describe below the general process by which a project was approved by CIG at the time in question in order to provide the Inquiry with a broad understanding of the different roles and responsibilities applicable to the parties involved in a business case review.

21. It is for health boards to develop the projects that they wish to deliver. SCIM 2011 (Bundle 3, vol.2, doc 33, p.141, para 3) makes clear that under no circumstances should responsibility for the direction and lead production of the business case be outsourced to external consultants.

22. The role of the Scottish Government is to consider those projects and to either approve or reject proposals. Projects within NHS Board delegated limits (as determined by extant Chief Executive Letters ("CELs"), named as such because they are issued by the Chief Executive of NHSScotland) do not require the approval of the Scottish Government.

23. When a health board wants to deliver a significant capital project (usually the upgrading of an older facility or the development of a new facility) it must first consider whether that is something that can be dealt with under the board's own delegated authority or

[2] Or equivalent post from time to time – post names have changed over the years

whether it requires reference to CIG. The determinative factor is the value of the project's capital expenditure. Annex C to the CEL dated 19 August 2010 (Bundle 4, doc 11, p.146) contained the delegated authority limits when I was in post. The delegated authority limits have since changed [see Director's Letter dated 12 September 2019] (Bundle 3, vol.3, doc 79, p.1,312).

24. Having identified the project as one falling outwith the delegated authority limit it is incumbent upon the health board to seek the Scottish Government's approval (via CIG). CIG encourages the early engagement of the health board and it is common for there to be several meetings between CIG and the health board prior to and during submission of the Initial Agreement, OBC and FBC (and any addendum thereto).

25. Having identified the parameters of the project the health board will submit an Initial Agreement to CIG for review and approval. The Initial Agreement sets out what the health board's proposal is about. It explains the current arrangements by which the health board is providing its services and why there is a need for change. The Initial Agreement will identify the proposed strategic/service solution(s) designed to meet the health board's need and should address the commercial, financial and management needs associated with the proposal which are to be more fully developed and subject to option appraisal within an OBC.

26. Once submitted, the Initial Agreement will be circulated amongst the members of CIG for review and comment. Any comments or questions would then be fed back to the NHS Board and subsequently NHS Board responses returned to CIG members to confirm whether issues had been closed out. Thereafter cases would be considered at a meeting of CIG. CIG will either approve or reject the initial agreement. CIG's consideration is guided by the advice contained in SPFM and SCIM. If the initial agreement is rejected the health board will be advised why with the health board either having the option to withdraw or revise the proposal. As with review at all stages, a rejection is likely to prompt the health board to revise its proposal and resubmit.

27. If the Initial Agreement is approved, the health board then prepares and submits an OBC to CIG for consideration (following approval of the OBC by the health board(s) concerned). The OBC is expected to reconfirm the objectives/ aims set out in the Initial

Agreement and, following an option appraisal, identify the preferred option for addressing the identified strategic/ service objectives. It is expected to demonstrate that the preferred option will deliver the necessary service change, optimise value for money, and be affordable and should set out the supporting commercial and management arrangements required for successful implementation of the option. A health board can only move on to procurement once it has received approval of its OBC.

28. Finally, the health board submits its FBC to CIG for consideration. The FBC should set out the agreed commercial arrangements for the project, confirm that it remains value for money, is affordable and that the organisation is ready to proceed towards implementation of the option. The FBC will be developed within the final procurement phase of the project and should record the detailed assessment and/or negotiations with potential service providers/ suppliers leading to the formal signing of contracts. A health board may also submit an addendum to its FBC if it requires further approval for matters not contained in (or derogated from) the FBC. In the case of a PPP/NPD project a FBC (Addendum) was a requirement to reflect the nature of the commercial agreement at financial close of the project given that there are a number of variables relating to the financing of the project that are only confirmed at the point of financial close (particularly in relation to the cost of debt).

29. The level of detail required in a business case review will depend upon the scale, risk and nature of the investment proposal. It will need to meet the expectations and information needs of CIG, who can be consulted at any time for advice on these expectations.

30. The business cases are circulated to the members of CIG to consider the content of the business case and the deliverability of the project. The CIG also examines the extent to which the project matches national, regional and local priorities set out in Local Delivery Plans and associated Property and Asset Management Strategies. Each CIG member focuses on their specialist specific area of the business case (e.g., financial or clinical aspects), and submits their comments to Health Finance & Infrastructure[3] in advance of the meeting. CIG members can also comment on other aspects of the business case if they consider it appropriate.

[3] This department was named 'Capital and Facilities' during my tenure.

31. CIG member comments are collated by Health Finance & Infrastructure, who may also seek further clarification from the health board if necessary, before the CIG meets to take a collective decision about the project. CIG members, acting as a group, decide whether to approve the project, and either seek the appropriate clarification from the health board(s) on issues to be resolved prior to making a recommendation for approval or, if endorsed, make the appropriate recommendation to the Director of Finance or Director General.

32. It is common for business cases to be subject to a process of development following initial review by CIG and updated drafts provided that address any issues/ queries/ concerns raised. It is also common for there to be an open dialogue between the health board and CIG as their business case progresses – in fact, this is encouraged. The process is designed to deliver affordable and effective solutions to health care needs across Scotland. It is in all parties' interests to see that that end goal is achieved.

33. The whole process from inception at health board level to approval of the Full Business Case by CIG can take many years depending on the nature and complexity of projects. There is also a requirement within the SCIM for NHS Boards to conduct Post Occupancy Evaluations and Post Project Evaluations. Scottish Ministers are involved throughout the Post Occupancy and Post Project evaluations. The Post Occupancy evaluation occurs six to eight months after opening looking at how the facility is operating. The Post Project evaluation is a longer-term review of how the service benefits are being met. I cannot comment on whether they were carried out in relation to the Project as I had left post by the time I would have expected these evaluations to be scheduled to take place.

34. The ongoing monitoring by Scottish Government post business case approval would be in relation to the financial profile and timescales for delivery on what had been agreed. This was exercised through ongoing financial monitoring of financial returns from NHS Boards to SGHSCD Finance.

The need for a new hospital

35. The requirement for a new hospital, which was originally to be named the Royal Hospital for Sick Children ("RHSC") and would later become known as the RHCYP was set out by NHS Lothian ("NHSL") in their Initial Agreement and then more fully in their OBC in 2008 and further developed regarding the DCN requirement in the addendum OBC in 2011. The need for the new hospital facilities was identified by NHSL and not driven by the Scottish Government.

36. The overview of the strategic case for the Project is set out in NHSL's OBC.

37. The role of the Scottish Ministers in the development and approval of business cases is set out at paragraphs 26 to 34 above.

38. The development of the business cases for the Project was ultimately a matter for NHSL. That said, I would describe the process as collaborative and myself, Norman Kinnear or other CIG members regularly made ourselves available to provide advice to NHSL with regards to the business case processes. As is often the case, much of this advice was provided in conversations both in person and over the telephone. Advice was given both in the run-up to the business cases being submitted to the SGHSCD for review and throughout the CIG review process. The last thing anyone wanted was for versions of business cases to be going backwards and forwards between health boards and SGHSCD when matters could have be resolved via a telephone conversation prior to submission of the business case. NHSL had appointed their own legal, technical and financial advisors for the Project, so would also have been taking advice from them too.

39. In addition, the Design Assessment process and Key Stage review (discussed further below) involved HFS, Architecture & Design Scotland ("A&DS") and the Scottish Futures Trust ("SFT"). These bodies did not form part of CIG but provided advice to the CIG. A&DS was also a statutory consultee in relation to applications for planning permission relative to the Project.

40. SFT sat on NHSL's Project Board once the decision to use the NPD funding route and to include DCN was confirmed. I explain this funding model further below. SFT provided advice on the commercial and financing aspects of the Project and undertook a Design Review shortly after the decision to switch the funding route of the project to assess the extent of the design work undertaken and the basis for the capital costs of the

Project. Key Stage Reviews were undertaken at defined points in the development/ procurement process as per the funding conditions set out in the Scottish Government Letter of 22 March 2011 (Bundle 3, vol.2, doc 43, p.376) and further comments at paragraph 140 below).

41. Detail on roles and responsibilities of NHSL's Project Board and various advisors were set out in Appendix 21 of the Final OBC dated 27 September 2012 (Bundle 3, vol.2, doc 55, p.502). Appendix 21 is a Project Execution Plan prepared by Davis Langdon (an AECOM company).

42. The role of NHSL's Project Board was Project Delivery Governance (see organogram at Bundle 3, vol.2, doc 55, p.501) and description of roles and responsibilities set out at p.501-510).

43. Mott Macdonald were engaged by NHSL as Project Manager and technical advisors to NHSL (Bundle 3, vol.2, doc 55, p.505) and provided NHSL with advice and input into their business case. Representatives of Mott Macdonald attended NHSL Project Board meetings, but not as Board members.

44. A range of advisors to NHS Lothian were involved in NHSL's development of the business case (Bundle 3, vol.2, doc 55, p.505) - legal and financial advisors as well as a significant range of professional interest within NHS Lothian.

45. In relation to the approval process, in addition to the members of the CIG considering the various iterations of the business cases, presentations were given at CIG meetings by NHSL (supported by NHSL's advisors). Again, Bundle 3, vol.2, doc 55, p.501-510) sets out range of bodies involved in workstreams, including external bodies that were part of process in relation to planning, etc.

46. The purpose of these presentations was to provide further context to the business case content around the planning and delivery of the Project, highlight areas for further discussion and offer an opportunity for CIG members to ask questions of aspects of the project including the information presented by NHSL.

47. Additionally, staff from SGHSCD were involved in the background in tracking progress against outstanding issues raised by CIG and liaising with NHSL on progress being made toward financial close.

48. I would describe the business case process as collaborative, with each party playing an important role (highlighting that each party had different roles). That was the approach encouraged by SGHSCD in providing advice and guidance through the development process to avoid unnecessary delays.

49. The process leading to the approval of business cases was iterative. There were a range of issues identified after submission of the business cases to SGHSCD that required resolution (including signing off Supplementary Agreement 6 ("SA6") prior to the commencement of procurement and, for the FBC, a range of issues identified by CIG).

50. NHSL had ultimate ownership of and responsibility for the preparation of business cases and their approval through their own governance structures prior to submission to Scottish Government.

Governance and Decision Making

51. NHSL are responsible for the provision of healthcare services sufficient to meet the needs of its health board area (and to contribute to the national provision of regional centres of excellence/specialism). For the most part, it is for NHSL to determine how those needs are met (as I explained above).

52. The need to build a replacement for the Sick Kids in Edinburgh was recommended by the expert Ministerial Advisory Group on child health, the Children and Young People's Health Support Group. The project sought to ensure that all acute inpatient children's services in Scotland would meet the gold standard of triple co-location of children, maternity and adult services. This complemented the existing children's hospital in Dundee, the new children's hospital in Aberdeen and the then planned new children's hospital development in Glasgow.

53. The decision to build a new hospital was made by NHSL, although, in accordance with the delegated authority limits that I referred to in this statement, the decision required the approval of the relevant Scottish Government Director General. The reasoning for NHSL's decision both on the need for and the proposed site for the hospital was further set out by NHSL in the Initial Agreement, developed in their OBC for RHCYP in 2008 and further developed regarding the DCN requirement in the addendum OBC for the DCN in 2011.

54. The decisions post-2010 in relation to the funding model to be used and the procurement process to be followed were taken by the Scottish Government as a direct response to the significant reduction in capital funding available from the UK Government. All major capital projects not yet legally committed were reviewed to assess options for deliverability through the NPD model in order that public capital funding could be best deployed against those projects and programmes for which the NPD model would have been unsuitable. This exercise was supported by SFT, at a Scottish Government level, as an input to the Scottish Parliament budget process. From this exercise, a £2.5 billion programme of NPD projects was developed, covering all major elements of the public sector, of which £750 million related to health (including RHSC/DCN). I provide further detail at paragraphs 65 onward below.

55. In relation to the system of governance in place at the Scottish Government for the Project in the period up until the start of the procurement process, I would first observe that the governance of the Project itself was a matter for NHSL.

56. SGHSCD's involvement was in relation to compliance with the SCIM, through CIG and Scottish Government more generally through the oversight of the Scottish Government's Infrastructure Investment Board (IIB) which had responsibility for monitoring the delivery of the wider Scottish Government supported infrastructure programme. The role of the IIB is covered further in paragraph 62 of my statement below, which I address in some detail.

57. In a wider sense however there was governance in place in relation to NHSL's performance and arrangements in place (financial and operational) to monitor that. This centred around financial and performance delivery against the objectives set in NHS Board Local Delivery Plans (LDP's) and supporting financial plans, which were

reviewed and agreed by the Scottish Government annually and monitored on an ongoing basis.

Site constraints and contractual issues with Consort

58. My understanding of the site constraints encountered by NHSL at the initial planning stages principally comes from the detail set out within SA6. NHSL would be best placed to address the site detail of the constraints they encountered and SFT and NHSL should be able to comment on the commercial arrangements.

59. The resolution of issues with the site and access were covered via SA6. SA6 documented an agreement between NHSL and Consort in relation to access to the land at the site, principles regarding enabling works and the interface between the new NPD facility and the existing Private Finance Initiative ("PFI") contract. This agreement was the basis of securing required support of the lenders on the Edinburgh Royal Infirmary (ERI) PFI contract for the changes to that contract on matters relating to the interface with the Project.

60. I believe there was a dispute between NHSL and Consort at the time unrelated to the Project, which related to maintenance within the ERI PFI contract. That dispute complicated the resolution of issues around SA6.

61. It was a commonly held position by SFT, SGHSC and Scottish Government's IIB, given the importance of de-risking the Project to avoid cost and delay, that it was important that issues associated with site boundaries and access were addressed to provide certainty to the project and to potential bidders. Scottish Government approval of the OBC, therefore, required that SA6 was resolved before a procurement could be launched in order to remove risk and uncertainty.

62. It might be helpful, at this stage, if I give a reference to the Inquiry to explain what the IIB's role was. The IIB's terms of reference are set out here: https://www.gov.scot/publications/infrastructure-investment-board-terms-of-reference/.

63. I cannot recall the Scottish Government providing direct advice to NHSL on the legal or technical aspects of the site constraints and the contractual dispute with Consort other than for the need for these matters to be resolved prior to the launching of the procurement exercise. NHSL were the client to the PFI contract and had legal advisors engaged to advise them in considering these issues. SFT were involved in the discussions in relation to SA6 and the contractual/commercial issues. The terms of SFT's involvement are captured in an SFT document provided by the Inquiry as document (Bundle 3, vol.2, doc 43(ii), p.388).

64. The Project was regarded as complex from the outset (see the IIB RHSC briefing at Bundle 3, vol.2, doc 54, p.484). That complexity was increased as a result of both the interface between the Project and the existing PFI neighbouring ERI hospital site and the change in funding route (to the NPD model – discussed below). If the funding changes had not been made, however, the RHSC would not have been affordable and neither it nor the DCN could have been delivered.

Switch to the Non-Profit Distribution Model ("NPD")

65. The RHSC Project was originally to be funded by way of public capital investment. This changed and an NPD model was ultimately used. The NPD model is a variant on previous private finance models, some of which were criticised due to the returns to the private sector being uncapped. The NPD model changed the financing structure to ensure that returns to the private sector were capped. The reason for the change to NPD, put simply, was a significant reduction in available capital funding available to the Scottish Government as a result of the 2007–2008 financial crisis. The UK Government had applied, at that time, a 36.5% cut in real terms over the Comprehensive Spending Review ("CSR") period, meaning difficult choices were required on the prioritisation of capital budgets not only as part of the ensuing year, but also for future budgets. The Scottish Government decided to use every lever to maintain capital investment – through the NPD model, tax incremental financing and the National Housing Trust. The Scottish Government's position was that these approaches sought to protect jobs and services. At the time of the announcement in late 2010 the aim was to minimise any delay on the

delivery of the Sick Kids preparing for procurement as quickly as possible and by providing support to NHS Lothian through the SFT.

66. The Scottish Government's funds are drawn from the Scottish Consolidated Fund ("SCF"). SCF is constituted by a block payment from Westminster as well as any revenue generated by the Scottish Government. In 2010 the payment from Westminster was significantly reduced. Accordingly, major developments required the investment of capital from the private sector. Consequently, and as I indicated above, decisions post-2010 were taken by the Scottish Government as a direct response to the significant reduction in capital funding available from the UK Government. Those decisions had to be made in relation to the funding of new projects against the background of already having significant capital funded commitments to other projects, including the Queensferry Crossing and the new Glasgow Hospital (subsequently named as the QEUH and RCH).

67. When looking at prioritisation within a capital funded programme, you consider which projects are legally committed. If a contract has been entered into, and you are seeking to halt that project, then that would mean breaking the contract and having to meet any penalties that came with that. With the Queensferry Crossing and the new Glasgow Hospital, there had also been very strong public commitments politically around both of these projects and, given their nature, the use of public capital was deemed to be appropriate rather than private finance. I am unable to recall what stage the procurements had reached for these projects at the time the funding routes were being proposed or if they were, at that stage, already legally committed. I believe that private finance was explored in respect of the new Glasgow Hospital (QEUH/RCH), but it was deemed undeliverable as the budgetary impact of the different accounting treatment between public capital and private finance would not have been financially sustainable for the NHS board (NHS Greater Glasgow and Clyde ("NHSGGC")).

68. As indicated above, the Scottish Government took the decision to switch to the NPD model. SFT were heavily involved, as the decision on RHCYP was part of a much wider review of planned projects, which led to the announcement of a pipeline of £2.5 billion of NPD investment across the public sector in Scotland that included health facilities, schools, housing etc.

69. The use of private finance (including NPD) is best suited to larger stand-alone new build facilities, generally in excess of £50 million, because of the relative costs of procurement and the risks are better understood. This is why private finance has been rarely used on existing buildings, where the risk profile is much higher and influenced by both the age and nature of the building as well as historic approaches to ongoing maintenance.

70. The project was assessed as being suitable for procurement under the NPD model due to a combination of factors. These factors included the scale of the Project and funding required to enable it to be developed; the known track record of hospital project delivery via private finance at the time; market appetite to take forward such projects; and the focus on using public capital for those projects/ uses that it was only suited to (for example, maintenance of facilities). Also, DCN had already been identified for delivery through NPD (albeit the DCN project had yet to be formally progressed), but by combining with RHSC/RHCYP there would be a single procurement given the siting of both facilities at Little France beside ERI.

71. SFT would be well-placed to explain in further detail the NPD model and factors that weighed in the balance as to its suitability for use for particular types of projects at the time that such decisions were taken. There were subsequent changes to the balance sheet classification of NPD projects as a result of the guidance on Managing Government Deficit and Debt ("MGDD") associated with the application of the European System of Accounts 95 ("ESA95"). This could not have been foreseen at the time that such decisions were taken.

72. NHSL was not consulted about the switch to NPD, prior to the decision being made. This decision was taken at a macro level across Scottish Government and as part of the Scottish Government's draft budget considerations. The budget still required parliamentary approval. I think it is somewhat unusual that NHSL was not consulted about the switch to NPD, prior to the decision being made; however, that was related to the situation with the draft budget that I have mentioned above. I cannot recall the exact timeline from when the decision was made and when NHSL were told of the change, however I believe this to be a matter of weeks rather than months. I believe Scottish Government and Scottish Futures Trust would be better placed to comment on this.

73. In relation to the statement at paragraph 67 of the Grant Thornton Report (Bundle 3, vol.1, doc 2, p.39) I cannot comment on a risk assessment as the decision to proceed with an NPD project was taken as part of wider budget considerations. SFT may be able to add to this. What I can say is that the alternative to NPD was that the Project would not have proceeded.

74. As SGHSCD operated in a collaborative manner with NHS Boards, ideally NHSL would have been consulted in relation to their preferred funding model. At the time, however, parliamentary processes had to be followed and, as I have said, the choice was between agreeing to a switch to the NPD model or having no funding to take the Project forward. There was simply insufficient capital budget available to fund the Project. The NPD model had been recommended to the Scottish Government by SFT, who had completed the development work on the finance model (having considered previous criticisms of private finance models). Had NHSL not wished to proceed with the Project or any part of it, NHSL could have withdrawn its business case at any stage of the process, although the project would not have been delivered.

75. In a briefing that I drafted for the DG Health and Social Care for the benefit of the First Minister dated 16 November 2010 (Bundle 3, vol.1, doc 29 (i), p.1120) I explained *"In moving to an NPD finance route the current procurement will require to be halted and a new procurement commenced as soon as possible. The Scottish Futures Trust have been requested to prepare a proposal, due within the next two days, on how it could support NHSL to develop an NPD procurement strategy as soon as possible. SFT have been given a clear brief to develop a proposal and strategy that minimises any delay in the delivery of the project. It is expected that, with appropriate input from both SFT and NHSL that a new procurement strategy could be ready within 4-6 weeks. An assessment of revised timescales would be possible at that point."*.

76. SFT were developing and advising on the particulars of the private finance model to be used. I am not aware of the NPD model itself having been used on any previous hospital project at that point; however, NPD was a variant on the established public-private partnership ("PPP") model with some changes in the funding structure with the aim of

capping returns to the private sector and reducing the overall cost of debt. PPP more generally was a well-established model in the health sector.

77. In relation to the DCN, Norman Kinnear was the lead Scottish Government official corresponding with NHSL in 2009 and again in 2011 on the options and OBC. I was Norman's line manager, so was sighted by him on the themes under discussion.

78. NHSL had, in November 2009, approved an OBC for submission to the Scottish Government regarding DCN, identifying a joint build with the RHSC/RHCYP funded through capital as NHSL's preferred option. At that time, I advised NHSL not to formally submit the business case to CIG at that time because the capital programme for NHSScotland was already fully committed over the period for development NHSL were proposing based on anticipated future funding available (note that this was also prior to the subsequent, significant reduction in capital budgets), meaning it would not be able to be ultimately approved at that time due to a lack of available capital.

79. In around December 2010 as part of the Scottish Government's wider review, with SFT, of planned projects (referred to above), the DCN was looked at again. As I said above, it would not in 2009 have been possible to fund the DCN through public capital funding given the forward profile of legally committed projects across NHSScotland and the projected funding envelope available, but a wide range of possible projects were being looked at again through the lens of possible NPD finance.

80. As of 11 January 2011, correspondence between Norman Kinnear and Jackie Sansbury, Chief Operating Officer of NHSL (Bundle 3, vol.2, doc 34, p.312), shows that NHSL's position was as follows:

> *"The position of NHS Lothian regarding DCN is that in Nov 2009 NHS Lothian approved an OBC for DCN identifying a joint build with RHSC funded through capital as our preferred option. At that time Mike asked us by email not to submit the business chase* [typo: case] *to CIG, indicating there was no capital available.*
>
> *The joint build remains our preferred option clinically, but you have advised that in order for us to proceed we must now redo the financial modelling demonstrating*

the costs under NPD (joint build with RHSC) and PFI (at the end of the ward arc) with some sort of alteration to the PFI contract.

This will not only delay the project due to the requirement to complete the modelling but on reflection this will also require some funding support from you for advisors as the posts can no longer be capitalised. I do know however Susan has already written to Mike re financial support for advisors.)."

81. I took from this that NHSL wished to progress the joint build of RHSC/RHCYP and DCN but were concerned that this would delay the Project (due to the requirement for them to complete/ update the financial modelling) as well as the larger project being more complex to deliver.

82. The decision to take forward the DCN as part of the Project was ultimately taken by NHSL when it decided to submit the addendum OBC for the DCN. The decision aligned with NHSL's preference to site both the RHSC/RHCYP and DCN at Little France.

83. The change in procurement route from capital funding to private finance did have an impact in terms of delay to the Project but it is impossible to quantify the time delay that arose simply because of the procurement route as there were other factors that led to timescale changes. The incorporation of DCN into the Project also had an impact on timescales, and again I cannot quantify the amount of delay. Overall, however, the question of how much delay arose from the change in procurement route is immaterial because if NPD had not been used for RHSC/RHCYP, that project could not have been delivered. Also, if RHSC/RHCYP and DCN had been separated, there would have had to have been separate procurements, leading potentially to three private finance contracts on the one site and all the complexities of the interfaces between them.

84. In relation to the question of whether the switch to NPD resulted in any increased costs to the Project, I cannot comment on the cost differential: there is no real comparator as public capital funding was not available to support the project.

85. Design work had been completed by BAM when RHSC was being developed under the Frameworks Scotland procurement approach to a level appropriate for OBC approval and delivered via public capital funding. Frameworks Scotland was the procurement

programme implemented by HFS to support NHSScotland at the time the original 2008 OBC for the RHSC was being developed, although this programme has been updated and amended twice since then. The Framework was an agreement with Principal Supply Chain Partners to enable NHS Boards and other NHS bodies to easily appoint contractors to progress the delivery of facilities without the need to undertake a full procurement process themselves. Frameworks Scotland was a further evolution of a procurement approach called "NHS ProCure21" which had previously been established in England successfully. Following the switch to NPD, the existing design work that had been completed by BAM was used to inform the reference design and scope of the Project. The decision to utilise the existing design work in this way was taken by NHS Lothian but supported by the Scottish Government and SFT. This was so that design work already undertaken was not wasted and would hopefully speed up procurement process rather than starting again.

Reference Design

86. My broad understanding of the difference between an exemplar design and a reference design is detailed below:

a) Reference Design

In public sector infrastructure procurement projects Reference Designs are detailed designs developed by the Procuring Authority, working with an architect or team of design consultants, before the tender bidding process. The resultant Reference Design is a close representation of the form of structure that the Authority is seeking at completion.

The Authority may allow some deviation from the Reference Design by the successful private sector tenderer but as the Reference Design is more detailed than an Exemplar Design (as described below) there will be less leeway to make significant changes to the Reference Design. The reference design does not include the technical or electrical requirements which would be developed by the

bidders as part of their tender response. The reference design was more to do with spatial configurations.

b) Exemplar Design

In public sector infrastructure procurement projects Exemplar Designs are prepared by the Authority, again often working with an architect or team of design consultants, before the tender bidding process and are a comprehensive, but conceptual, design brief that establishes the Authority specifications and requirements.

In response to the Authority's project specifications provided through the Exemplar Design, the private sector tenderer produces a detailed design to meet the design brief.

The Exemplar Design does not provide detailed construction information as to how the project is to be constructed, instead it provides what the Authority requires and the risk of 'how' to construct the project to meet the specifications of the Authority is transferred to the successful private sector bidder.

87. The Scottish Ministers did not make the decision to adopt the reference design, but the procurement approach that was taken by NHSL was agreed with Scottish Government and SFT. NHSL had not wanted to waste design work undertaken, and this was supported by SFT and Scottish Government on time and cost grounds. There was a balance to be struck as NHS Lothian had invested considerable time, effort and money into identifying what the service requirements for the RHSC were and how those were to be met under the previous Framework Scotland procurement. However, it was also important that bidders had sufficient scope for innovation. The balance of risk between NHS Lothian and the bidders also had to be considered, by applying accepted principles set out in extant accounting standards and HM Treasury Guidance

88. Various questions have been raised by the Inquiry in relation to mandatory and non-mandatory elements within the reference design. I was not directly involved in the development of the reference design. That was not the role of Scottish Government. The

reference design approach is described within the OBC submitted for the Project in 2012. NHS Boards routinely taken their own advice in the preparation of investment proposals and in developing business cases, as NHSL did here. Each member of the CIG had different areas of expertise and advice was also obtained from relevant bodies such as HFS, A&DS and SFT as necessary and appropriate. CIG relied upon all such input during the consideration of business cases.

89. Scottish Government's interaction with the reference design process was limited to the business case approvals process and as indicated above, facilitating contact with colleagues who had knowledge of the use of reference design within procurement in Northern Ireland. The reference design process (including the decision to adopt the reference design approach) was undertaken by NHSL. SFT undertook a design review in November 2011. Scottish Government's role was limited to the business case process and, via the analysis undertaken by SFT, the use of the reference design to establish the forecast capital and revenue costs of the proposal, not the detail of the reference design.

90. Appendix 5 of the OBC (makes clear that one of recommendations of the IIB to NHSL is that "preparing a "reference design" for the Project is likely to have benefits in this case, particularly considering the work undertaken to date, and recommends that the project team [NHSL] work closely with SFT to assess bids in relation to whole life costs, to ensure value-for-money."

91. The Grant Thornton report (Bundle 3, vol.1, doc 1, p.30), at paragraph 107, confirms that the decision to make use of the work produced by BAM was supported by the Scottish Government and SFT. At paragraph 117 it states: "The decision to make use of this work was supported by Scottish Government and Scottish Futures Trust. The benefit of this was set out in the project board minutes as being able to make the procurement timeline as short as possible." I agree with this synopsis.

92. I would also cross-refer to (Bundle 3, vol.2. doc 39, p. 354) where it is noted that at a project discussion of 1 February 2011 that I attended with Jackie Sansbury, Susan Goldsmith, Iain Graham, Norman Kinnear and Donna Stevenson, design development was discussed and I suggested that NHSL should make contact with someone (John Cole, the then Head of Health Estates in Northern Ireland) from Health Estates in Northern Ireland to learn from work done there in relation to reference design, given the use of

reference design as part of the established procurement process for health estates in Northern Ireland.

93. The Inquiry wishes to know if the adoption of the reference design approach was unusual, given the number of mandatory elements. Given the number of mandatory elements in a PPP procurement, greater discretion would usually have been given to bidders than was given for the Project. This was, however, the first NPD and the circumstances (switching from capital funding to NPD) had no precedent in Scotland. The use of reference design in health capital projects had however, been applied in Northern Ireland successfully and I advised HFS to engage with Mr John Cole, Head of Estates Planning at Health Estates Northern Ireland. Mr Cole had developed a procurement methodology in Northern Ireland which had used the reference design through PFI, I believe for example the South West Acute Hospital in Enniskillen.

94. My understanding of the driving factors behind the decision to adopt a reference design with so many mandatory elements was that there was sufficient clarity from NHSL on their service requirements, meaning that the additional costs of bidders each developing designs from scratch would have led to additional costs and delays. The reference design approach limited the level of innovation from potential bidders, but a balance had to be considered for innovation against NHSL being clear on their requirements and reducing the cost and time for the delivery of the project. That said, the approach made clear those areas where bidders would be required to innovate.

95. I am not able to describe what is meant by the term "operational functionality" with reference to design – that was not my area of expertise on the CIG. As I have already stated, each member of the CIG brought their own particular areas of expertise and relied upon the expertise of other members and external bodies such as SFT, HFS and A&DS for their expertise.

96. NHSL would have appointed healthcare planners as advisers under the Frameworks Scotland approach to assist with developing clinical service models and capacity planning. This would also have considered adjacencies of clinical specialisms. NHSL would be able to assist the Inquiry with the role healthcare planners that they appointed had in the development of the reference design.

97. My understanding of the role of NHSL in the decision to adopt the reference design approach was that considerable time (including that of clinical teams in developing service models) and cost had been committed to the development of the design and NHSL did not want to delay the project any longer than was necessary.

98. My understanding of the role of SFT in the decision to adopt the reference design approach is that SFT reviewed the procurement approach through both direct involvement and via the Key Stage Review process. I would refer the Inquiry to SFT's correspondence of December 2010 (Bundle 3, vol.2, doc 31, p.108).

99. I was not directly involved with Mott MacDonald directly (they were advising NHSL) so cannot comment upon their role in advising NHS Lothian on the decision to adopt the reference design approach.

100. I cannot assist the Inquiry on whether other parties were involved in the decision to adopt the reference design approach – this would be a question for NHSL. As I have indicated above, the reference design approach was endorsed by both Scottish Government and SFT for the reasons I have set out. The 2012 OBC sets out a preferred option and the design, at that point, would not be fully formed (as in this instance).

Design Assurance

101. As detailed in paragraph 1.2 of the SFT Report (Bundle 7, doc 14(ii), p.464) the arrangements for agreement of project scope included an independent design review (which was conducted on behalf of SFT by Atkins). It was the role of SFT to be satisfied that NHSL had appropriate design parameters and assumptions in place and report to CIG as to whether they were so satisfied. This was consistent with the terms of the funding conditions guidance issued by SGHSC. It was not Scottish Government's role to undertake design assurance or put in place design assurance processes as the project was the responsibility of NHSL.

102. Primary responsibility in respect of infrastructure planning rests with the NHS Board. Page 36 of the SCIM (2011) Business Case Guide states:

"The ownership and responsibility for the infrastructure investment planning process rests with the NHSScotland Body developing or leading the development of the programme/ project in question"

103. As part of this process, design assurance responsibility rests with the health board for the design and delivery of projects.

104. In relation to whether an NDAP assessment took place in respect of the Project, I would highlight that SFT undertook a design review at an early stage to assess the then status of design development relative to the procurement process. Also, A&DS was a statutory consultee in relation to planning permission for the Project. Any issues raised through the statutory consultation process would have required to have been addressed in order to secure planning permission. The responsibility for securing that planning permission rested with NHS Lothian. The FBC required to address whether planning permission had been confirmed prior to the Project proceeding.

105. I have no recollection of whether SFT, or any other party, provided advice to the Scottish Ministers with regards to whether an NDAP assessment should take place. The process, including independent design review, was agreed for NPD schemes and set out in the funding conditions letter (Bundle 3, vol.2, doc 43, p.376). The role of SFT in respect of design was establishing capital costs of the project, whether those were reasonable and the revenue consequences of that. With regards to SFT's role design assurance was also set out within that letter from Peter Reekie to Jackie Sansbury dated 1 June 2011 (Bundle 3, vol.2, doc 46, p.399). I agreed the terms of Peter Reekie's letter to Jackie Sansbury. With regards to whether an NDAP review was carried out alongside the Atkins review, I have only had sight of the Atkins review.

106. There were a number of design review processes undertaken as part of the project's development. These are summarised in paragraph 1.70 of the Outline Business Case (Bundle 3, vol.2, doc 61, p.685). In December 2011, I had requested the SFT Atkins Design Review Report to be shared with HFS and A&DS to ensure there was an

alignment of processes that had existed at the earlier stages of the RHSC project and those subsequently introduced as part of the Design Quality Policy for NHSScotland introduced via CEL (19) 2010. I have no recollection of the nature of the follow up to this request.

107. The role of the Mott MacDonald (if any) in respect of design assurance was directly agreed with and linked to NHSL, so I cannot comment further on that other than that the support of technical advisers was referenced by NHSL in paragraph 2.94 of the OBC. Paragraphs 2.94 to 2.97 (Bundle 3, vol.2, doc 61, p.700-701) set out the purpose of the reference design and this was part of the OBC approved by the Scottish Government.

108. The role of the NHS National Services Scotland ("NHS NSS") in respect of design assurance was as part of business case review and engagement with NHSL. There had been engagement between SFT, A&DS and HFS as to their respective roles in developing the project under Frameworks Scotland procurement and subsequently as part of the NPD as set out in paragraph 1.70 of the OBC. Given the respective roles of SFT, A&DS and HFS, I had requested that the SFT commissioned Atkins report be shared with HFS and A&DS and for a meeting to be convened to ensure there were no gaps.

109. In relation to what other parties were involved in the design assurance process, NHSL may have employed specialist technical advisors, but NHSL would have to provide any details to the Inquiry.

110. NHSL had ultimate responsibility for design assurance (see reference to overall accountability on page 36 of SCIM Business Case Guide) (Bundle 3, vol.2, doc 33, p.156).

Health Facilities Scotland

111. I understand that the Inquiry is interested in the technical standards applicable to the health services in Scotland. In particular, the Scottish Health Technical Memoranda ("SHTM").

112. NHS NSS provides services and advice to the NHS and public sector. NHS NSS is a non-departmental public body established under s10 of the National Health Service (Scotland) Act 1978. NHS NSS is independent of, but accountable to, the Scottish Government.

113. HFS is the division of NHS NSS that has particular responsibility for the provision of operational advice and guidance to health boards on a range of healthcare facilities topics. HFS is responsible for establishing professional and technical standards and best practices. In particular, HFS is responsible for the publication of the Scottish Health Technical Memoranda ("SHTM").

114. SHTM are directed at those NHS boards in Scotland providing healthcare services. The memoranda cover a range of technical practice areas and provide comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare. SHTM apply to new and existing healthcare sites and are for use at various stages during the lifecycle of a facility.

115. The Scottish Government are not responsible for the publication of SHTM (see paragraph 141). My role required me to be aware of SHTM and their importance, however, and as I explained above, the technical application of SHTM is a matter for those providing healthcare services.

116. NHS Boards are responsible for the facilities they operate, development of business cases and the application of the guidance set out within the relevant SHTMs. After 2010 and the introduction of the design assessment process and the involvement of HFS in that respect, there was a clear expectation that NHS boards had to ensure compliance of the projects they owned with SHTMs and technical standards.

SHTMs

117. HFS are responsible for the preparation and publication of SHTM and can provide information in regard to the powers and/or duties they act under. From knowledge I

believe the drafting of the SHTM is done through a committee of technical/health experts from across the UK.

118. SHTMs are directed to NHS Boards and more widely. It was important that contractors and advisers had access to the SHTMs. SHTM communication is a matter for HFS, and they would be able to advise as to how they did that, including using their networks.

119. Again, I would refer you to HFS in relation to the intended role and purpose of SHTMs and how they relate to other categories of guidance, such as:
    a. Scottish Health Facilities Notes
    b. Scottish Health Planning Notes
    c. Scottish Health Technical Notes
    d. Scottish Health Building Notes

120. HFS would also be able to explain those other categories of guidance (including who issues them, their broad purpose, their legal status and mandatory force (if any), and to whom they are directed).

121. In relation to the question of to what extent compliance with SHTMs is mandatory: SHTMs are guidance, but some aspects will flow from mandatory requirements set out elsewhere, such as in the Policy on Design Quality for NHSScotland (CEL 19 (2010)) (Bundle 4, doc 9, p.99), which includes 8 mandatory requirements for NHSScotland Health Bodies to do various things (e.g. comply with EU, UK and Scottish Government procurement policy and guidance; develop Design Statements when procuring new-build and refurbishing healthcare buildings; use ADB and Design Quality Indicator tools).

122. I expected any derogation or deviation from SHTMs to be highlighted as part of the NHS Board's business case. Whether any derogation or deviation was actually disclosed is a different question, but my clear view is that the obligation was upon the health board concerned to adhere to the guidance set out in SHTMs. There are layers of governance within the health boards around the development of these projects and the health boards interact with the bidder to be compliant.

123. It is possible to derogate from SHTMs. If a derogation was being sought, I would have expected the relevant health board to engage with HFS as technical experts in relation to any proposed derogation. I would also expect the relevant health board to provide a clinical justification and/or carry out a risk assessment dependant on the circumstances and for that to be reflected in the business case or as a specific request. The onus would be on the relevant health board to progress any derogation requests. To my knowledge I have not heard of a request for derogation from an SHTM being made. When I was Deputy Director, the only derogation I recollect is the one related to the move away from the single-room policy and that related to a CEL not a SHTM. I engaged with HFS and Jackie Sansbury on this matter in 2013 and this was deemed a reasonable request with clinical justification and was approved.

124. The NHS boards are responsible for the development and delivery of the project and for any contracts they enter in to. The assurance mechanisms that existed within the NHSL Board should have been sufficient to ensure they were compliant and meeting obligations. I do not think that those responsible for the design, planning, construction and operation of hospitals have discretion to unilaterally depart from SHTMs. I would expect NHSL Board to engage with HFS, both in relation to any proposed departure from SHTMs or in the case of a SHTM not covering a particular situation, being thought to be ambiguous or superseded by changes, for example in legislation or best practice (this happened in relation to fire codes and waterborne infections pseudomonas following an incident in a neo-natal unit in Wales). In such circumstances, HFS may look to update the SHTM. Again, HFS is best placed to address this.

125. I am not familiar with the detail of what SHTMs, or other similar documents, applied to the ventilation systems in the Project. Again, HFS would be able to address questions on this. No derogations were sought, to my knowledge.

126. I am asked about SHTM 03-01 Part A v. 2 (February 2014) (Bundle 1, doc 9, p.618) and SHTM 00 v. 2.1 (February 2013) (Bundle 1, doc 7, p.333) each containing a disclaimer (pages 5 and 4 respectively). HFS would be better placed to answer questions as whether to similar disclaimers appeared in earlier versions of the guidance and explain the disclaimer(s) and why it is (they are) present.

127. The Scottish Government does not have responsibility for the content of SHTMs in general, or in particular to the version(s) of SHTM 03-01 and SHTM 00 (and their predecessors) which applied to the Project. That responsibility rested with HFS. I am unable to comment on the consequences of failing to comply with SHTM requirements and not aware of any SHTMs not being complied with and derogation being sought.

128. The Scottish Government is responsible for the SCIM. HFS is responsible for technical guidance that supports the development and operation of facilities. My particular focus was the finance and funding and compliance with the SCIM in that respect. The revenue consequences would be reviewed by Scottish Government's Health Finance Division. In relation to RHCYP in particular, because it was a regional (and indeed in some respects national) facility, NHSL had to engage with other boards (in Tayside, Fife and South East Scotland) around the financial consequences for them of the new hospital and accessing its services. The Full Business Case contained approvals from relevant NHS boards that supported the decision to proceed.

129. The SHTM 03-01 Part A v. 2 (February 2014) (Bundle 1, doc 9, p.618) contains an acknowledgement thanking a Steering Group led by the Department of Health, and contributors, for producing HTM 03-01 Part A; (Bundle 1, doc 8, p.438) states that "*HTM 03-01 Part A has been updated and amended by Health Facilities Scotland for use in NHS Scotland as SHTM 03-01 Part A and the contribution from the National Heating & Ventilation Advisory Group is gratefully acknowledged"* (page 6). There is equivalent guidance that applies in England and Wales. There was engagement across the UK administrations to produce the guidance. I understand that there was some differentiation between the Welsh, Scottish and English guidance to take account of any differences in legislation in the different jurisdictions. This was not uncommon around technical guidance generally. HFS will be able to advise more fully on this as they were participants in the process but the Policy on Design Quality in NHSScotland and the requirement for use of ADB set out at Annex B of that document stresses the need for NHS Board to ensure that the requirements of Scottish specific guidance are taken into account.

Chief Executive Letters

130. A CEL is an instruction to the NHS by the Chief Executive of NHSScotland around what needs to be done and how it should be done. The contents and subject matter vary. The relevant policy division is responsible for drafting and advising, guided by the relevant director. CELs are not developed in isolation. CEL 48 for example was the consequence of wider engagement across the system via the Single Room Steering Group and the revision of Capital Planning arrangements via CEL 32 (2010) (Bundle 4, doc 11, p.146) a consequence of the work of the Capital Strategy Group.

131. The Scottish Government is responsible for (a) drafting and (b) issuing CELs. They are issued in accordance with the relevant established delegation of functions in terms of statute and established framework governing the relationship between SGHSC (acting under the Cabinet Secretary for Health and Social Care) and NHS Boards.

132. The process that is followed before a CEL is issued varies depending on the nature of the subject. In the case of the SCIM, Capital Planning Arrangements and Single Room Policy working groups had been established with interests from across NHSScotland participating in the development of policies and/ or guidance.

133. CELs are addressed to the Chief Executives of NHS Boards and, when issued, are copied to Directors within NHS Boards with responsibilities in relation to the subject matter of the particular CEL (e.g., Finance, Estates, etc.). In my time in post, there were also weekly bulletins that were put out to NHS Boards and accessible from the Scottish Government's website, which made others aware of CELs. Scottish Government expected that the recipients of CELs would cascade the information to all who should be referring to it. Technical advisers to NHS Boards should be aware of CELs both through engagement with their clients and through general public access to the information.

134. The intended purpose of CELs is contained within the narrative of each CEL.

135. In my view, CELs each set out their own requirements in respect of compliance: some will include mandatory requirements and others may not. I refer to the previous example I have given of CEL 19 (2010), (Bundle 4, doc 9, p.99), which includes 8 mandatory requirements. CELs are issued under the authority of the Scottish Government's Director

General for Health and Social Care, who is also the Chief Executive of the NHS in Scotland.

136. I am asked what the consequences (if any) of failure to comply with a CEL are. I would highlight that (at least in my time in post) neither the Scottish Ministers nor HFS are auditors of NHS Boards' compliance with legislation, regulation or guidance issued to them. NHS Boards have their own governance responsibilities and, at least in my time in post, were expected to manage their own responsibilities as appropriate. Broadly, I would say that any consequences will depend entirely upon on the terms of the CEL (which are widespread and varied) and the nature of and deviation from the guidance set out in the particular CEL.

137. In my opinion, those responsible for the design, planning, construction and operation of hospitals have no unilateral discretion to depart from CELs. As above, I would expect the NHS Board to engage with HFS both in relation to any proposed departure from CELs or in the case of a CEL not covering a particular situation, being thought to be ambiguous or superseded by changes, for example in legislation or best practice. I had regular engagement with HFS and I cannot recall any such issues being raised with me. If issues with CELs had been raised with HFS, I would have expected HFS to advise Scottish Government that the CEL should be reviewed with a view to updating it. Again, HFS is best placed to address this.

138. I am asked what Chief Executive Letters, if any, applied to the ventilation systems in the Project; were any derogations sought from their requirements? If yes, how and when, and for what reasons? Were they granted? And if yes, how and when? I can only answer, this far removed from my role as Deputy Director, that I cannot recall any specifics. I do not recall any derogation being applied for in relation to the ventilation systems. I can only recall general coverage in relation to the operation of the SCIM, the single-room policy – beyond that I cannot think of any occasion.

Status of other relevant guidance

139. As I have explained at paragraph 10, the Scottish Public Finance Manual (SPFM) sets out Scottish Government guidance on the proper handling and reporting of public funds and the sector specific SCIM provides Scottish Government guidance, in a NHS Scotland context, on the processes and techniques to be applied in the development of all infrastructure and investment programmes and projects within NHSScotland. SCIM guidance is clear that the ownership and responsibility for development of projects rests with NHS Boards. In regard to the Project NHSL would be responsible for setting out their requirements and ensuring that these are consistent with SHTMs and complied with by the contractor.

140. The Policy on Design Quality for NHSScotland and mandatory requirements in relation to the use of the Activity Database ("ADB") as well as the NDAP were introduced through the 2010 revision to SCIM. SCIM sets the expectation that SHTMs will be followed. Responsibility for compliance rests with the NHSScotland health boards, in this case NHSL. HFS are there to define and update standards and to provide technical advice and support to NHSL. The role of Scottish Ministers is to set the overall policy framework. They do not have a direct intervention role, however there is a requirement for them to have oversight via the assessment of the Initial Agreement, OBC and FBC relevant to projects and also via SFT were responsible for Key Stage Reviews which were a requirement as set out in the funding conditions letter issued by the Acting Director General for Health and Social Care on 22 March 2011 to NHSScotland (Bundle 3, vol.2, doc 43, p.376).

141. If we consider the phased development of a hospital and the business case process, there are three stages to it. The exception to this was the Project as we had to revisit the OBC to deal with the change of funding route and the incorporation of the DCN unit. The Initial Agreement sets out the strategic requirement for a project and identifies problems/issues that need to be resolved. The OBC then follows, which carries out an options appraisal and assesses cost benefits and risk. . Following this you have the FBC, where the preferred option for the project has been identified and the final costs, timetable and the procurement option are confirmed. Scottish Ministers are involved throughout all of these stages, and their involvement then continues via the Post Occupancy and Post Project evaluations. NHS Boards are responsible for compliance and should be on top of

their brief and are responsible for compliance through their own governance and assurance processes.

Decision to design the RHCYP/DCN to include multi-bed rooms

142. David Hastie was the Deputy Director for Property and Capital Planning in 2006. At this time the role still fell within the remit of the Scottish Executive. In 2007 the SNP came into Government and this title changed to Scottish Government. Norman Kinnear was the major capital projects advisor and a key interface with NHS boards in relation to developing projects. He was also heavily involved in the single rooms steering work. The Scottish Executive issued interim guidance in 2006 pending further studies.

143. The Single Room Steering Group was formed in 2006 to consider a number of factors relating to single/multiple occupancy rooms, including infection control, overall hospital design and wider health benefits within the hospital environment and develop a Scottish approach.

144. I cannot provide detail on the extent to which the November 2008 single-bed policy led to a review and update of all relevant technical guidance. HFS was responsible for updating technical guidance and would be best placed to comment.

145. I came to the issue of single/ multi-bed rooms in late 2008. I was aware of the interim policy position from 2006 and, in general terms, the work of the Single Rooms Steering Group. There had been a general move across the UK and beyond towards the use of single-bed rooms in hospitals. SG health directorates and HFS were members of the European Health Property Network and there was research being done (which is explicitly referred to in the Scottish Executive's Interim Guidance for NHSScotland Provision of Single Room Accommodation in 2006 (Bundle 3, vol.1, doc 5, p.152)) on the costs and benefits of single rooms across the world. That research was also linked to infection control and a range of other matters related to the impact of the patient environment on the effectiveness of healthcare. There had been a clear move away from mixed-sex accommodation and an important element was the fact we had multi-bedded bays on hospital wards. For example, if there was a 4-bed bay with 3 men in it, a health

board couldn't place a female in the empty fourth bed. NHSScotland also had an aging hospital stock, including within the DCN in Edinburgh where there were only 20% single rooms. There were a range of considerations to be taken into account, which were addressed by the work of the Single Room Steering Group (Bundle 4, doc 1, p.5) I am not sure of the date of the change, but the description 'HDL' ceased to be used for guidance issued and subsequent guidance was issued with the description of 'CEL'.

146. I am unable to recall, given the passage of time and the limited extent of my involvement in the issue in 2008, the detail of the decision-making regarding the quantity of single-bed rooms for RHSC beyond what was contained in the OBC, i.e., that 58% of rooms would be single (Bundle 3, vol.1, doc 12, p.321). I am aware of references in the subsequent OBC regarding agreement by the Chief Medical Officer ("CMO") to the position but have no recollection of that. I was a member of CIG prior to 2009 and had oversight of the SCIM process, but at the time of the submission of the OBC in 2008 the interface between CIG and the CMO for queries on business cases and the single-bed rooms would have been Norman Kinnear. I expect he would have linked in with the CMO and Chief Nursing Officer (CNO) and Paul Martin who had chaired the single-bed rooms steering group.

147. The nature of CELs varied dependant on the subject matter and each would set out the basis of requirements on NHSScotland bodies. Some included certain mandatory requirements (and I discuss this further below). The CEL dated 11 November 2008 (Bundle 4, doc 1, p.5) was the basis of an instruction to NHSScotland Boards as to what should be done from that date. In terms of single-bed rooms, I would expect a derogation to be applied for if there were to be deviation from the terms of the CEL that applied at the relevant time.

148. The Scottish Executive's Interim Guidance for NHSScotland Provision of Single Room Accommodation dated 15 December 2006 (Bundle 3, vol.1, doc 5, p.152) sets out the interim guidance in place in August 2008, when the OBC was approved. This provided that there needed to be a minimum proportion of single bedded rooms of 50%. The OBC for RHSC was submitted in July 2008 and was approved in August 2008. It complied with the interim guidance extant at the time. The introduction of the new 100% single-bed room policy, CEL 48 (11 November 2008) (Bundle 4, doc 1, p.5), did not require

reconsideration of the accommodation arrangements proposed for the RHSC/RHCYP. The CEL specifically stated that "NHS Boards should implement the new guidance in all schemes in excess of delegated limits that have not yet submitted Outline Business Cases". The RHSC/RHCYP accommodation requirements were, therefore, based upon the interim guidance that was extant at the time when the 2008 OBC was prepared and approved. NHSL submitted an addendum update business case for the DCN once the addition of the DCN was introduced in 2013, but that did not require a revisiting of the business case for the RHCYP.

149. The configuration of the Project was determined by NHSL, having reference to the guidance that pertained at the time. The role of Scottish Government was approval of the business case. The business case set out NHSL's approach to service configuration, addressing benefits and risks for patients. I would have expected that the business case would set out NHSL's approach to configuration having had regard to the relevant guidance and CELs. That is what it did in so far as it complied with the interim guidance specifying that there needed to be a minimum proportion of single bedded rooms of 50% for the RHSC/RHCYP and a derogation was sought (and approved) for a less than 100% single-room provision for DCN.

150. Decisions about the proposed configuration of the patient rooms in the Project were taken by NHSL based on their identified service requirements. I am aware of references in the updated Project OBC (Bundle 3, vol.2, doc 61, page 672) that refer to the bed modelling and research undertaken with stakeholders that derived the position taken in the 2008 OBC regarding the proportion of single-bed rooms. I do not recall being involved in the exchanges relating to that approval. Before a business case is prepared the relevant service models need to be understood. The updated service model detail is contained within the updated Project OBC (Bundle 3, vol.2, doc 61, page 672) reflecting on the further development of modelling between 2008 and 2012.

151. Business cases received by the Scottish Government Property Capital Planning division (part of SGHSCD) were circulated to members of the CIG, which included the CMO and CNO Directorates, for comments. When I was in post there were templates that were completed for each project and comments would be gathered and sent back to the NHS Board, keeping an audit trail of issues raised and what was addressed. This was an

administrative task and carried out by the Secretariat to CIG located in the then Property and Capital Planning Division within SGHSCD. .

152. CIG had a number of discussions with NHSL about the proposals in its business case – I cannot recollect how many and when, but it was common in complex projects for the NHS Board to engage regularly on points of process. NHS Boards including NHSL would be invited to present their project to CIG, giving CIG the opportunity to ask questions based on the presentation and business case if that had been received prior to the meeting. Equally NHS Boards would be able to ask CIG members questions on aspects of business case development.

153. The rationale from the NHSL Board for single-bed rooms for RHCYP is contained in the 2008 OBC (Bundle 3, vol.1, doc 12, p.272) the 2012 OBC (Bundle 3, vol.2, doc 61, p.672) and the FBC (Bundle 3, vol.3, doc 76, p.729). Different guidance applied as between the RHSC 2008 OBC and the subsequent DCN OBC and the FBC for the Project. For the avoidance of doubt, this means that 2006 guidance applied to the RHSC and 2008 guidance applied to the DCN.

154. Some of the rationale for multi-bedded rooms in RHSC related to the fact that it would not be beneficial for some children to be kept in isolation. Other factors included provision for family support and addressed the fact that this was a hospital that was to be a facility for local, regional and national needs. These issues were addressed in NHSL's business case, which set out rationale for rooms required (Bundle 3, vol.2, doc 61, p.672).

155. In relation to the DCN and the particular derogation from single rooms requested there, particular clinical needs in relation to neuroscience were addressed; in particular I recall one of the key reasons for the request for a derogation was based on clinical observation needs. I recall this being a particular factor in relation to this request for derogation being approved. The CMO was consulted in relation to these requests for derogations.

156. NHSL requested approval for a derogation in respect of the DCN in 2013. NHSL's rationale in respect thereof is produced (Bundle 4, doc 17, p.182). I received that request and, as it required the approval of the CMO, I wrote to the CMO, appending the detailed explanation for the derogation provided by NHSL. The CMO wrote back to me

confirming that he approved the derogation, and I wrote back to NHSL to confirm that (bundle 4, doc 19, p.189). The Inquiry is therefore correct in understanding that a derogation from the single-bed room requirements of CEL 48 was sought by NHSL and granted by the Scottish Government (upon receiving the approval of the CMO) for the DCN in 2013. NHSL having identified what they considered to be the correct specification to provide the service, the technical specification would flow from that (not the other way around).

157. I am asked about how, once the new single-bed room policy was introduced, those responsible for the accommodation arrangements in the RHCYP were made aware of it. CEL 48 (Bundle 4, doc 1, p.5) was issued to all NHS Chief Executives with the usual expectation that they would follow normal custom and practice and cascade the CEL down through their respective organisations.

158. I am told by the Inquiry that it understands that SHTM 03-01 Table A1 (and its predecessor SHTM 2025) do not make explicit provision for ventilation arrangements in multi-bed rooms and asked whether I agree and various follow-on questions in relation to this guidance. I am not able to answer these questions. They would be better directed to HFS, who are the producers of the guidance and are the technical experts on its development. NHSL and HFS would be able to answer the Inquiry's questions on how provision for ventilation in multi-bed rooms was understood and the extent to which it was taken into account, when (a) initially deciding the RHCYP should include multi-bed rooms, and (b) when the single-room policy was introduced. In relation to interpretation of the guidance and its application to the RHCYP it is the responsibility of NHSL and their technical advisers to consider the guidance in setting out their technical requirements

159. I do not know what, if anything, was said to potential bidders about how ventilation guidance was to be applied to multi-bed rooms for the DCN – those would be matters for NHSL, supported by their technical advisors and the bidders to assist the Inquiry with.

Answers to questions posed in the Rule 8 request dated 10 February 2022

160. I have been asked to confirm whether, to be the best of my knowledge and belief, certain understandings held by the Inquiry team are correct. I confirm that:

1. *In November 2008, the Scottish Government's Chief Nursing Officer issued a letter containing updated guidance on the provision of single room accommodation (CEL 48) (Bundle 4, doc 1, p.5). It directed NHS Boards to implement the new guidance in all schemes exceeding delegated limits in which Outline Business Cases had not yet been submitted. The guidance, insofar as relevant to the Inquiry, was that for all new-build hospital and other healthcare facilities with in-patient accommodation, there was a presumption that all patients were to be accommodated in single rooms, unless there were clinical reasons for the use of multi-bed rooms.*
2. *The first Outline Business Case for the RHCYP is dated 1 July 2008 (the "2008 OBC") (Bundle 3, vol.1, doc 12, p.272). It was submitted to and approved by the CIG before CEL 48 (Bundle 4, doc 1, p.5) was issued (the Scottish Government's approval being dated 15 August 2008), such that the new guidance would appear not to have applied to the RHCYP. The guidance applicable when the 2008 OBC was approved was the Interim Guidance for NHS Scotland Provision of Single Room Accommodation dated 15 December 2006 (Bundle 3, vol 1, doc5, p.152).*
3. *The 2008 OBC (Reprovision of Royal Hospital for Sick Children - OBC) (Bundle 3, vol.1, doc 12, p.272) states that a mix of single-bed and four-bed rooms was found to be most desirable, and that the working assumption for the RHCYP was that it would have at least 50% single-bed rooms (paragraphs 6.5.1 and 6.5.3). A footnote in the 2014 Final Business Case refers to an approval by the Chief Medical Officer in 2008 (paragraph 2.8.1), but does not otherwise explain what process (if any) led to that decision[4]. A Single Room Accommodation report was produced.*
4. *CEL 48 (Bundle 4, doc 1, p.5) noted that further work was needed on the suitability of multi-bed areas for specific patient groups and to identify clinical specialities where 100% single-bed rooms would be mandatory. A consultation*

[4] NB - In my role as Head of the PFCU in 2008 I was not involved in that directly and have no recollection of exchanges. If the Inquiry needs more information on this, I would suggest SG should be able to cover from correspondence and papers relating to OBC consideration at the time

exercise by Delphi was underway to that end. Separate advice was to follow. Health Facilities Scotland were to be asked to review and update all relevant technical guidance, and to lead work to develop a risk matrix tool in conjunction with others including the Single Room Provision Steering Group.

5. *The Delphi Consultation Exercise established that single rooms were clinically appropriate in most specialities but identified eleven specialities where that was not always so. Reasons were given. For such specialities, four-bedded bays which could be subdivided into single rooms were considered a more appropriate option. For children and adolescents, 100% single rooms were seen as best practice; specialist advisers in surgical and medical paediatrics considered 100% single rooms should be provided in those specialities.*
6. *In July 2010, the Scottish Government's Health Finance Directorate issued a letter confirming as policy for NHS Scotland the presumption that there should be 100% single rooms in future hospital developments (CEL 27) (Bundle 4, doc 10, p.144). Certain exceptions were identified, including where there were clinical reasons for different arrangements. The letter required that any such reasons should be clearly identified and articulated in the appropriate Business Case. Each case would be subject to Scottish Government agreement as part of the Business Case approval process.*
7. *A further Outline Business Case was published in 2012 (the "2012 OBC"). (Bundle 3, vol.2, doc 61, p.672). The purpose of this business case was, through an addendum, to deal with the re-provision of the DCN and to change the funding structure; and that the substance of the 2012 OBC in relation to the RHCYP remained as in the 2008 OBC (Bundle 3, vol.1, doc 12, p.272). The 2012 OBC referred to the approval of the 2008 business case, and its proposed mix of single and shared accommodation. It said that 58% of in-patient beds would be in single rooms.*
8. *The Scottish Government had confirmed in January 2011 that the clinical options appraisal did not need to be updated for the 2012 OBC.*
9. *The 2014 Full Business Case (Bundle 3, vol.3, doc 76, p.729) contained similar provision (paragraph 2.8.1) and noted that this had been approved by the Chief Medical Officer in 2008 (footnote 14, page 17).*
10. *Health Building Note 23 "Hospital Accommodation for Children and Young People" (23 October 2014) does not refer to CEL 48 or CEL 27, or to the need*

for Scottish Government approval of anything less than 100% single rooms. It states that 100% single-bed rooms offered maximum flexibility; 50% single rooms were considered best practice; and 20% single-bed rooms were considered a minimum requirement.

161. The Inquiry has identified certain guidance and Scottish Government correspondence as being relevant to its terms of reference. The Inquiry has indicated that these include Scottish Health Technical Memorandum 03-01 – Ventilation for Healthcare Premises Part A – Design and Validation ("SHTM 03-01 Part A") (Bundle 1, doc 8, p.433) and so-called "Chief Executive letters" including CEL 48 (November 2008) (Bundle 4, doc 1, p.5) and CEL 27 (July 2010) (Bundle 4, doc 10, p.144) on single-room accommodation. I have no personal knowledge of the narration given by the Inquiry as to the different versions of SHTM 03-01 or SHTM 00.

162. In relation to Health Facilities Scotland, I confirm broad agreement with the facts set out by the Inquiry as being:

1. *Both SHTM 03-01 and SHTM 00 were published by Health Facilities Scotland ("HFS").*
2. *HFS is part of the Procurement, Commissioning and Facilities division of NHS National Services Scotland ("NHS NSS"); that NHS NSS is the name given to the body established in statute as the Common Services Agency; and that the statutory basis for NHS NSS is currently section 10 of the National Health Service (Scotland) Act 1978 and the National Health Service (Functions of the Common Services Agency) (Scotland) Order 2008.*
3. *Under section 10(7) of the 1978 Act, NHS NSS is required to act "subject to, and in accordance with" directions given by the Scottish Ministers. Under section 10(3), the Scottish Ministers may delegate to NHS NSS such of their functions relating to the health service as they consider appropriate. (The 1978 Act refers to the Secretary of State but, following devolution, such references are to be read as meaning the Scottish Ministers: section 53 of the Scotland Act 1998.)*
4. *The functions delegated to NHS NSS under the 2008 Order include the provision of "information, advice and management services in support of*

the functions of Scottish Ministers, HIS, Health Boards and Special Health Boards" (2008 Order, article 2(f)).

5. *HFS "provides operational expertise and guidance on subjects related to healthcare facilities" and it "establishes professional and technical standards and best practice procedures".*

6. *HFS has formed part of NHS NSS since 2006, when the Property and Environment Forum and its executive body, the Property and Environment Forum Executive ("PEFEX"), became part of NHS NSS and were renamed HFS.*

7. *The Prefaces to SHTM 03-01 and SHTM 00 provide an introduction to SHTMs (pages 7 and 5 respectively). These state that SHTMs give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare. They explain that the focus of SHTM guidance remains on healthcare-specific elements of standards, policies and up-to-date established best practice. They refer to healthcare providers having a duty of care to ensure that appropriate engineering governance arrangements are in place and are managed effectively. They state that the SHTM series "provides best practice engineering standards and policy to enable management of this duty of care". They explain that the suite is not intended to repeat unnecessarily international or European standards, industry standards or UK Government legislation, but that where appropriate those would be referenced. They state that SHTM guidance was the main source of specific healthcare-related guidance for estates and facilities professionals. They state that the suite provided access to guidance which was more streamlined and accessible; encapsulated the latest standards and best practice in healthcare engineering; and provided a structured reference for healthcare engineering.*

8. *The Executive Summary to SHTM 00 states that it is provided as a comprehensive guide to all issues relating to the management of engineering and technical service provision wherever NHS patients are treated. It states that, whilst it is not intended to cover every possible scenario, its standards and principles may be appropriate to follow in all locations where healthcare is provided. It states that the aim of SHTM 00*

was to ensure that everyone concerned with the management, design, procurement and use of a healthcare facility understood the requirements of the specialist, critical building and engineering technology involved. It states that, regardless of the procurement route, it is essential that, as part of the briefing process, those involved in the provision of the facility are advised that all relevant guidance published by HFS was available electronically for purchase[5] from HFS. It states that only by having knowledge of these requirements could a healthcare organisation's board and senior managers understand their duty of care to provide safe, efficient, effective and reliable systems which were critical in supporting direct patient care. It states that it was expected that appropriate governance arrangements would be put in place to reflect these responsibilities, supported by access to suitably qualified staff to provide the informed client role. It states that by locally interpreting and following the guidance, NHS boards and individual senior managers should be able to demonstrate compliance with their responsibilities.

9. *SHTM 00 recommends (page 9) that boards and chief executives, as accountable officers, use the guidance and references provided, inter alia: when planning and designing new healthcare facilities; and when developing governance systems which take account of risk. The Executive Summary concludes by stating that "Once NHS Boards and Chief Executives have embraced their principles set out within this document and taken the necessary actions, their duty of care responsibilities are more likely to be fulfilled".*

10. *Both SHTM 00 and SHTM 03-01 carry a disclaimer in the following terms:*

> *"The contents of this document are provided by way of general guidance only at the time of its publication. Any party making use thereof or placing any reliance thereon shall do so only upon exercise of that party's own judgment as to the adequacy of the contents in the particular*

[5] From memory there may have been a different approach for public bodies and for the private sector at one time - HFS would need to confirm this. The CEL in 2010 on Design Quality refers as a footnote to Annex B of the development of "Space For Health", which was a UK wide initiative to electronically host guidance material. I cannot recall when the development of this completed or how it was implemented.

circumstances of its use and application. No warranty is given as to the accuracy, relevance or completeness of the contents of this document and Health Facilities Scotland, a Division of NHS National Services Scotland, shall have no responsibility for any errors in or omissions therefrom, or any use made of, or reliance placed upon, any of the contents of this document."

163. I believe that the facts stated in this witness statement are true. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.

By typing my name and the date below, I accept that this is my signature duly given.

Signed : MICHAEL BAXTER
Date: 20 APRIL 2022