SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
9 May 2022

Day 1
Monday 9 May
Janice MacKenzie

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THE CHAIR: Good afternoon, Ms MacKenzie. As you're aware, you are about to be asked questions by Mr MacGregor, who is on my right. First, can I ask you if you'll take the oath?

THE WITNESS: Yes, I will.

Ms Janice MacKenzie

Sworn

THE CHAIR: Thank you very much, Ms MacKenzie. Can I just say that we have quite a lot of electronic equipment in front of us, some of which is designed to amplify the voice. I for one am hard of hearing, so I always appreciate if a witness is prepared maybe to speak just a little louder than you might otherwise. I think there may be benefit in using the directional microphone. I am sure everyone else can hear perfectly. I am just thinking about myself.

THE WITNESS: Okay.

THE CHAIR: Right. Mr MacGregor.

Questioned by Mr MacGregor

Q You are Ms Janice MacKenzie. Is that right?

A That's correct.

Q And you've provided a witness statement to the Inquiry.

A I did, yes.

Q Which is dated 20 April 2022, and for the benefit of the core participants, it's in bundle 6 at pages 4 to 14 of the bundle. The content of the statement is going to form part of your evidence to the Inquiry and I'm also going to ask you some questions today. If at any point you want to refer to your statement, please do let me know, and equally if at any point you would like to take a break, please do just say so.

A Thank you.

Q If I could begin by covering your qualifications and experience. You qualified as a nurse i 1981. Is that correct?

A That's correct, yes.

Q And you retired in 2019?

A I did, yes.

Q If we could just go back to the start of your career, am I right in thinking that you completed children's nursing training, qualifying as a registered children's nurse in 1983?

A In 1982.

Q 1982. Can you just explain to the Inquiry, what does a registered children's nurse do?

A I initially trained as an adult general nurse and then I did what we called a post-registration qualification for a year to allow me then to care for children and young people.

Q And where did you work

when you qualified?

A When I qualified as a children's nurse, I went down to London and worked at Great Ormond Street Children's Hospital.

Q And how long did you work there for?

A I was there for 15 years in a variety of different roles.

Q And eventually within that role did you become a senior nurse?

A I did, yes.

Q And there came a point where you moved back to the Royal Hospital for Sick Children in Edinburgh?

A I did, yes, in 1990.

Q In 1990, and in 2005, were you appointed chief nurse for acute community children's services?

A I was, yes, in Edinburgh, and that covered the children's service in St John's Hospital in Livingstone as well.

Q And what did that role involve?

A So that role involved-- I managed the nursing provision for those services. I was also part of the children's services clinical management team and that team had operational responsibility for all of children's services.

Q At paragraph 3 of you statement you say that, "A key element of my role was to ensure that patients and families receive patient centred, safe and effective care."

A That's correct, yes.

Q What do you mean by "patient centred, safe and effective care"?

A That was basically ensuring that the care that the patients were receiving was being delivered correctly, and we undertook that in a variety of different ways. We would audit the care that was being provided to the children and young people. We would also seek feedback from families as well as dealing with any complaints or positive feedback that we received.

Q So as part of your role as chief nurse, safety was one of the parts of your role?

A It was, yes, along with the medical director.

Q How would your role as chief nurse sit with that of the medical director? How did the relationship work?

A So we worked very closely together. We would both deal with any complaints that there were in relation to any clinical aspects of care, also any clinical audits that were being

undertaken.

Q Were you involved in any form of clinical governance?

A Yes, I was. Yes, myself and the medical director took the lead for that for children's services.

Q What do you mean by clinical governance?

A So clinical governance basically encompasses a number of factors. So it's in relation to any audits that we carry out, also monitoring of hospital-acquired infections, also the actual care being delivered, reviewing any incidents that had happened, looking at any clinical risks and any change in practice that may be required as a result of that.

Q Thank you. I want to ask you about the proposed reprovision of the Royal Hospital for Sick Children. At this stage, the Inquiry is interested really in the preliminary stages up until the procurement exercise for the new hospital was carried out. You were involved in the project from 2006 onwards, is that correct?

A That's correct. Initially in my chief nurse role, yes.

Q So, if we can focus initially on the period from 2006 to 2011, what was the nature of your involvement with the project?

A So at that point, really,

there was there was two elements to my involvement. One was leading on the patient focus and public involvement, so ensuring that there was effective consultation with children, young people, and their families and relevant charities that were involved in the hospital, and also in providing clinical input to the project team about early discussions about design of the hospital, what might be required, and working with my own senior nursing team to look at those elements.

Q Within paragraph 5 of your statement, you introduce a number of groups. You see that you refer to there being a PG1 core project team. What was that?

A So, at that point, I wasn't-- the core project team were the people that comprised and directly worked in the project team, so that would have been the project director, the lead medical person. I wasn't directly involved in that group.

Q There was a core group?

A Yes, of the----

Q Although you were involved in the project, you weren't part of the core group----

A No. So that group would also include the project managers.

Q Then you refer to a group

called “Clinical Redesign”. What was that?

A So that really was looking at how we were going to deliver the services in the new hospital, so kind of what changes we would need to make in relation to patient pathways and generally how we were going to deliver care differently because obviously, moving into a new building, we didn’t want to just move what was currently in the hospital; we wanted to be more efficient in our patient pathways.

Q So were you involved in the Clinical Redesign group?

A I was certainly involved in aspects of it, yes.

Q Who else would have been involved in----

A So all of the clinical teams were involved in that. So we would look at the patient pathways for patients being admitted with medical conditions, surgical conditions, and that would look at-- from the minute the patient was referred to the hospital, so be that from their outpatient journey then to being admitted and then to discharge, we looked at accident emergency pathways. So there was a variety of different pathways that were explored.

Q Then you referred to a

“Steering Group Design & Construction”. What was that?

A So that group was basically looking at what the design of the hospital was going to be and obviously the type of construction. I wasn’t directly involved in that group at that time.

Q Did you have any discussions with that group?

A Sorry?

Q Did you have any discussions with that group?

A I would have had, yes.

Q Again, feeding into it rather than being part of it.

A Yes.

Q You then refer to a group called “Workforce”, what do you mean by that?

A So that was a group that was looking at the workforce that would be required and within the new hospital and whether or not the workforce would need to change, both from a skill mix point of view and whether or not there was additional workforce that would be required.

Q Then you refer to the “Children and Young People’s Advisory Board”. Can you explain what was the Children and Young People’s Advisory Board?

A So the Children and

Young People's Advisory Board was formed to ensure that we had effective consultation and engagement with patients and their families, also any charity organisations in relation to the new hospital. I co-chaired that group with a parent member from the Family Council.

Q What was the real driving force behind that group?

A Well, it was to ensure that patients and their families had a voice in the new hospital and that we were aware of things that were important to them and that we met those needs.

Q At a practical level, how did the group go about its task?

A So the group itself met monthly. It had representatives. Obviously it had parent representation. We had staff on it and we had charity representatives on it. We undertook a wide variety of different consultation events at-- from kind of questionnaires to going around just talking to children and young people on the wards. We also-- At that time, the existing hospital had street fairs once or twice a year, and we would just go and talk to people. We tried to be as innovative as possible in how we sought views – particularly of younger children – and we did a lot of that through using art,

and we got kind of specialists in to do that.

Q If I could ask you to have in front of you, within bundle 4, page 9, there's a document called "Record of Involvement" dated January 2011. Do you see that?

A Yes, I do.

Q Have you seen this document before?

A I have, yes.

Q Could just explain what is this document?

A So this document basically recorded all of the consultation and engagement that was undertaken up until 2011, and that was to-- so that we ourselves as a project had a record of that, but it was also for the Scottish Health Council who had been formed by the Scottish Government to ensure that there was effective consultation and engagement in relation to any new project.

Q If we just look at a few examples. If we look, for example, four entries down, there's a date of December 2006----

A Yes.

Q -- and it says: "To consider how will involve parents of children with complex health care needs." Do you see that?

A Yes.

Q It says: "Meeting with Ann Wilson, Contact a Family". You're mentioned together with Rose Byrne. Just as an example, what would that entry be recording?

A That would be a recording that we met with Contact a Family, which is a charity that specifically supports families with complex needs, and we would have discussed at that meeting how best to elicit the views of those families. That then resulted in an agreement that we would ask parents to complete a questionnaire.

Q Within the bundle, still within the Record of Involvement, if we looked to page 13, please.

A Yes.

Q Do you see the second last entry there, which is for 21 November 2009? The entry says: "Inform of progress of project and share concept design." Do you see that?

A Yes.

Q So is that really a-- recording a discussion that's taking place in relation to the concept design for the new hospital?

A So that basically was recording that we were providing feedback to more of the kind of general public. So that was happening

at a Christmas fair, that was happening at the hospital, and the general public would come to that as well as families. So it was a poster display, and members of the project team would be there to answer any questions that people had.

Q Then if we move through them, page 15, the third last entry, there's a series of dates including 27 March 2010 through to 26 June 2010. We see that recording: "To seek the views of the young people on the 1:200 design." What was that?

A So that-- basically, we formed a young people's advisory group in 2007 because, whilst we had the Family Council which had parent representatives, we didn't have a group specifically for young people. So that would have involved the project team and the then architects at that time going along to the young people's group and showing them the designs at that point at the 1:200 level so that they got their input and feedback, and to-- whether or not from a young person's perspective, the design was meeting their needs.

Q Whenever we see (inaudible) for all the-- all those, we see: "Reprovision team… Nightingales" then the next entry: "Reprovision team & BAM" What are

those entries recording?

A So, again, those entries are recording that there was feedback and consultation with relevant groups, with the project team, and the architects.

Q So effectively input from children's and young people being conveyed directly to the design team.

A Yes, and because, obviously prior to that stage in the design, the young people had already given their views about things that were important to them, so it was to see had the design actually taken account of those issues. So I suppose, as way of an example, the young people had said to us previously that the current playrooms that we had in the old hospital were very focused on young children and they wanted facilities that were more young people friendly. So in the new hospital, we had planned for specific recreational areas for the young people. So that was to-- So they would input into that.

Q If we could just look at the final entry on page 15, this is again consulting on concept design. There's an entry, it says: "Reprovision team and HFS" What's the reference to HFS?

A So that would have been Health Facilities Scotland. Go back to

what it said(?). Thanks. So that would have involved, from my memory, looking at the concept design and HFS being involved in that, but I don't recall directly myself being involved in that so I'm not sure what they discussed.

Q You mentioned a body called Health Facilities Scotland. What's Health Facilities Scotland?

A So Health Facilities Scotland is a Scottish Government body that looks at more of the facilities side of buildings, etc. Again, I'm not-- I wasn't directly involved in it.

Q So from 2011 onwards, you tell us in your statement that you were asked to join the project team. Is that right?

A That's correct, yes.

Q Who asked you to join the project team?

A So I was asked by Brian Currie, who was the new project director at that point because the previous project director had left, as had the clinical lead, so that he had recognized that there was a gap in the project and there needed to be some more direct clinical involvement. So I was asked to join initially on a kind of part-time basis. So I spent 50 per cent of my time working with the project and 50 per cent of my time I carried on with my chief nurse role.

Q You've mentioned the project team and you've mentioned yourself and you've mentioned Brian Currie; who else formed the project?

A There would have-- at that time, there was several project managers and administrative support and, as the project progressed, then the project team had additional members joined.

Q Approximately how many people would be on the project team?

A In 2011, there would have probably been about seven or eight people.

Q And as the project went on, did that number increase or decrease?

A It increased.

Q In relation to the project team, who was the project team effectively reporting in to?

A So the project team reported to the project sponsor and ultimately to the health-- NHS Lothian Health Board.

Q Now, what do you mean by the term "project sponsor"?

A So that was the executive director who had responsibility for the project overall and was the link with the executive team at the Health Board.

Q Who was that?

A At that time, it was Jackie Sansbury.

Q So, if I can just make sure I am understanding, effectively the chain here in terms of governance: you would have the actual Health Board itself at the top, then you would have the project sponsor who sits on the board but is effectively a link between the board and the project team.

A Yes, and we also had a project board as well that the project sponsor chaired, and that had people from the project team on it as well as representatives from the children's services management team and other key individuals.

Q So you had the project team, but you also had a project board as well?

A Yes.

Q And did you sit on the project board?

A Not initially at that time, but when I became full-time on the project, yes, I did.

Q So, in 2011, you are part of the project team, but not part of the project board, is that right?

A Not that I can recall.

Q So, just again trying to think about people in the project team, who was on the project board, as you

understood it, at this time?

A So obviously the project sponsor chaired it, the project director was on it, some of the project managers would attend at times. I certainly did attend the project board at times if there was key issues to be discussed. The director of operations and the medical director from children's services were on that, the head of estates I'm sure was on the group, infection control were represented. They probably were the key people. There were-- There was somebody from Scottish Government and there were some other people, but I can't recall.

Q In terms of the project team, can you just explain to the Inquiry how that worked? Did people work individually? Did you work collectively? Were things discussed at meetings?

A No, we worked very collaboratively, partly to ensure that everybody in the team knew what was happening so anybody could kind of pick up any issues. Obviously, people had pieces of work that they were leading on, but we had regular-- we had weekly team meetings to ensure that everybody knew what was happening. We worked in an open-plan office, so it was very easy to kind

of know what was happening and we often supported each other. So when there would be meetings with clinical teams, etc., there was always at least two people from the project team attended those so that there was always somebody there to kind of answer any queries if the other person was off.

Q So I just want to make sure I am understanding this: there are the formal meetings that you said were approximately fortnightly, is that right?

A So we-- the project team had weekly meetings----

Q Weekly meetings.

A -- with the whole project team there, and the project board met monthly.

Q But, in addition to that, you also mentioned there was a lot of informal communication.

A There was a lot of informal communication, yes.

Q Can you just talk us through what was exactly your role within the project team at this time from 2011 onwards?

A So my role was to ensure that there was effective clinical inputs into the project and to ensure that, from a design perspective, it met the clinical requirements. I was the key link with the clinical teams, so that--

and any professional teams as well, and I provided advice to the project team, to the architects and anybody, really, else that asked for my advice.

Q Were there any other clinicians in the project team at this time?

A So several of the project managers had a clinical background, so they were on-- so they were-- obviously had a clinical background, and I say, because I had worked in children's services, I obviously know the clinical teams very well, so I would regularly meet with the clinical teams.

Q If we could return then so I can ask you some questions about the Children and Young People's Advisory Board, I think you mentioned that you co-chaired that group, is that right?

A Yes.

Q And it met, you say in your statement, from 2006 until approximately 2009.

A Yes.

Q What was it seeking to do? What was the Children and Young People's Advisory Board seeking?

A So it was seeking to ensure that we were consulting and engaging with children, young people and their families, and that any

information that we received was being fed back into the project.

Q You have mentioned that a questionnaire was sent out to patients and families. If I could ask you to look within bundle 4 at document 3 on page 17----

A Yes.

Q -- is this the questionnaire that you are talking about?

A Yes. That was one of the questionnaires that we sent out, yes.

Q If we look at the types of questions that were being issued, for example, question 6, there is a question, “All single en-suite rooms” – do you see that?

A Yes.

Q Why were you asking that question?

A So we were aware that at the time that the Scottish Government was looking at whether or not new builds should be 100 per cent single rooms, so the project team had asked us to include a question to children, young people and families about what their views were about single rooms or whether or not we should have a combination of single rooms and bedded bays. So that's why we included it.

Q We also see at question 7, they have been asked, “Combination of single en-suite rooms and 4/6 bedded bays.”

A Yes.

Q Was that obviously linked in with question 6 in terms of the rationale?

A Yes.

Q What responses did you receive to that questionnaire?

A So the questionnaire went out to a number of different groups. Obviously, it went out in general terms to children and young people and their families, but we also sent it out through Contact a Family that I spoke about earlier. We also sent out through the hospital and the Outreach Teaching Service because the children and young people that they support tend to be very difficult to reach, so that was a good way to do that. So the overall, in relation to the question about single rooms and whether or not a combination of single rooms and bedded bays, was that there was support for there being a combination.

Q And approximately what was the level of support?

A So it did vary in different groups. Certainly the hospital and Outreach Teaching Service, which is

primarily young and older-- sorry. It's primarily teenagers and also children and young people who were utilising the Child and Adolescent Mental Health Service, so they were more in favour of single rooms, which we fully expected would happen, and in the new build we certainly took account of that, but the rest, about kind of 70/80 per cent, were in favour of a mixture.

Q Are you talking about, in terms of young children, there was support for multi-bed rooms?

A Young-- Yes, but they’re kind of under-teenagers, yeah. Yes.

Q Were clinical staff consulted on similar issues?

A Yes, they were. So the project team led on getting clinical staff's views on what the bed configuration should be.

Q What views did clinical staff express on this issue?

A So the clinical staff were not supportive of having 100 per cent single rooms for a variety of reasons, certainly around patient safety and the ability to observe children, particularly young children. There was also concern about the isolation factor for young children of being in a single room and the impact that that would have on their development, particularly if they were in hospital for a prolonged

period of time. Also, not all children do have their parent being resident with them, and we know that young children in a single room, that that is very difficult for them. Also, just from a purely practical point of view, young children are not able to seek the attention of a nurse. They can't use a nurse call button. Also, children do tend to clinically deteriorate much more quickly than adults do. So there was a real concern that if all of the children were in single rooms, the observation of them would be very difficult.

Q In terms of the views that you have expressed in your statement, particularly at paragraph 9 and paragraph 21, would you agree that really the justifications for not having 100 per cent single rooms really boil down to issues of, firstly, safety for children and then, secondly, children having a feeling of isolation?

A Yes.

Q Was that view shared by the Young People's Advisory Group?

A It was, yes. It was. They had visited several hospitals, we had facilitated that, several new-build hospitals, and they felt strongly that there should be a mixture, and they wanted the option themselves of whether or not they wanted to be in a

single room or in a mixed-- in a four-bedded bay.

Q Can I ask you to look at a document, please, in bundle 4, Document 4 at page 19, please? Is this a document headed up, "Feedback on single room accommodation"?

A Yes.

Q And is it completed by a Gary Buchanan?

A That's right, yes.

Q He is described as interim co-chair. Was he co-chairing this group with you?

A No, he was co-chairing it with a member-- one of the project managers from the project team.

Q You can see Mr Buchanan states:

> "Firstly we felt it necessary to have a combination of both single rooms and bedded bays.
>
> We understand that in terms of hygiene, single rooms are easier to clean and maintain, however we feel that for babies and toddlers individual rooms are not going to work. This is because babies and toddlers need to be watched constantly and this would be difficult if they were in individual rooms as oppose to bedded bay with a

nurses station. Also it could be detrimental socially as they like to someone to play with.

Aberdeen Children's Hospital has a nice layout of bedded bays as they are bright and they had lots of room too."

Do you see that?

A Yes.

Q So did that effectively reflect not just the views of the Young People's Advisory Group, but also your own views?

A Yes.

Q If I could ask you, within the same bundle 4, to look onto the next page, please, to page 20. You see there is a document called Single Room Provision in Scotland Draft Nursing Report of March 2007?

A Yes.

Q Have you seen that report before?

A I have, yes.

Q Can you just explain to the Inquiry, what was this draft nursing report?

A So, this was a report that was produced by the Scottish Government through the nurse directors group, so that group had all of the board nurse directors from every board in Scotland on it and they were looking at, obviously, the single room provision. NHS Lothian's nurse director was on that group and she was aware that we had undertaken consultation in relation to single rooms, so we were asked to give our response to that.

Q If we look to page 22 of the bundle, please, the third paragraph on that page. You see that it states:

"The use of a building impacts on not only infection prevention and control but has also been linked to patient dignity, confidentiality, reduction of errors, positive patient outcomes, staff satisfaction and patient satisfaction."

A Yes.

Q Would you agree with those views in terms of there are other issues in addition to infection prevention and control that need to be considered in relation to a hospital?

A I would, yes.

Q Within the same document, look to page 25 of the bundle. There is the heading "Children's Services".

A Yes.

Q It says:

"As part of the Reprovision Project to replace the Royal Hospital for Sick Children in Edinburgh, a number of

consultation initiatives took place with small groups from charity and volunteering organisations. One of the questions that was asked was:

'Should the patient areas have single rooms or … 4/6 beds or a mixture of both?'

Responses indicated a mixed view depending on the organisation approached. However children, young people and their families preferred an option that included but was not exclusively single rooms. The majority of respondents preferring a mixed room approach."

And is that, effectively, the response summarised from the survey that we have looked at?

A Yes.

Q It continues:

"Currently children and young people are allocated single rooms prioritised on the following criteria: infection requiring isolation; mothers who are breastfeeding; terminally ill; adolescents."

And it continues:

"Views of Children's Nurses:

Not all parents will stay with their child overnight or are visiting the hospital all the time during the day. Children and many young people often feel very isolated and alone when they are in cubicles and enjoy the social interaction of being in a ward area beside other children.

In addition younger children and babies, unlike adults, are not able to use nurse call systems and therefore observation of them is more difficult if all were to be nursed in single rooms.

Children as part of their development require social interaction and for those who are unable to mobilise and confined to their bed and therefore not able to use the playroom, benefit from being nursed beside other children."

Again, is that really a summary of the views that you had receive from clinical staff in terms of the discussions that took place in the Edinburgh project?

A Yes, it is.

Q I am going to now ask you some questions about government policy on single-bed rooms, particularly in the period from 2006 to 2009. Before we go on and look at the documents, what was your general understanding of Scottish Government policy in that period on single-bed

rooms for a hospital?

A So I obviously was aware of the three guidance that the Scottish Government issued, the first one in 2006 stating that there should be an arrangement of 50 per cent, 75 or 100 per cent single occupancy rooms and then that view changed in the other two documents, where it said that there should be 100 per cent provision of single rooms unless there was a clinical reason to deviate from it.

Q So, if we could perhaps just look firstly at the interim guidance from 2006, so that is in bundle 3, volume 1, document 5, at page 152. You see a document headed Interim Guidance for NHS Scotland, Provision of Single Room Accommodation?

A Yes.

Q If we just perhaps read (inaudible) the first paragraph it says "…enabling beds to be provided in an arrangement of 50%, 75% or 100% single occupancy rooms." Is that what you're referring to?

A Yes.

Q Further down in the last full paragraph on page 152 it says:

> "In making any decision on the appropriate level of single room provision you should be fully aware of the changing perceptions described above including the recommendations contained in the EuHPN Report."

Do you know what the EuHPM Report is?

A No, I don't.

Q Then:

> "In planning for the construction or major refurbishment of healthcare facilities it is appropriate to provide an overall single occupancy room level of between 50% and 100%. The appropriate level within that range is a matter for each individual NHS Scotland Board to consider…"

Do you see that?

A Yes.

Q So at this point, perhaps moving towards 100 per cent, but it has got to be at least between 50 and 100. Just to complete that document, if you look on to page 153, we see that that was issued on 15 December 2006.

We can then go to bundle 4 please, to page 60. That document, headed up Recommendations From the Steering Group Report on Single Room Provision. Have you seen this document before?

A Yes, I have, yes.

Q What is this document?

A So this this document is

providing-- says the recommendations from the steering group about the single room provision and the background to it and the rationale for the recommendations that they were providing, in relation to proportion of single rooms.

Q If we see just below paragraph 4 where it states "New-build Facilities", the first bullet point:

> "All new-build hospitals or other healthcare facilities which will provide inpatient accommodation there must be a presumption that all patients will be accommodated in single rooms, unless there are clinical reasons for multi-bedded rooms to be available."

Do you see that?

A Yes.

Q So a shift in policy now; it is a presumption of 100 per cent single rooms unless there is a clinical justification otherwise?

A Yes.

Q If I could then ask you to look within bundle 4, document 1 on page 5. It is that document in the top right-hand corner that has got "CEL 48 (2008)" dated 11 November 2008.

A Yes.

Q It is issued by the Scottish Government and states "Provision of Single Room Accommodation and Bed Spacing" and then below, the bold paragraph on action, it says:

> "NHS boards should implement the new guidance and all schemes in excess of delegated limits that have not yet submitted Outline Business Cases. For schemes within delegated limits the guidance should be applied for such projects that have not commenced procurement. The guidance is as follows:"

Then for new-build facilities:

> "For all new-build hospitals or other healthcare facilities which will provide inpatient accommodation there should be a presumption that all patients will be accommodated in single rooms unless there are clinical reasons for multi-bedded rooms to be available."

Do you see that?

A I do.

Q So, in 2008 when you were involved in the project, was that your understanding of Scottish Government policy?

A It was, yes.

THE CHAIR: My fault Mr Macgregor, the bundle reference?

MR MACGREGOR: So it is bundle 4, document 1, on page 5.

THE CHAIR: Page 5, thank you.

MR MACGREGOR: Just to complete the Scottish Government guidance, if I could ask you still within bundle 4, to look to document 10 please, on page 144. Again, is this a document issued by the Scottish Government, top right-hand corner "CEL 27 (2010)" dated 20 July 2010?

A Yes.

Q Bundle 4, document 10 at page 144. At paragraph 1 it firstly makes reference to the chief executive letter, the CEL 48 that we have just looked at and then at paragraph 3 it states:

> "That process has now been completed, and a number of conclusions reached, including: the current provision of single room accommodation is not sufficient across NHSScotland; and 100% single room provision is clinically appropriate in most clinical settings."

Then at paragraph 5:

> "Accordingly, the Chief Medical Officer has concluded that the guidance set out in the above CEL that there should be a presumption of 100% single rooms in future hospital developments, is confirmed as the policy for NHSScotland except for: existing accommodation…"

That is the first bullet point and then the second bullet point:

> "In new developments where there are clinical reasons for not making 100% single room provision they should be clearly identified and articulated in the appropriate Business Case. However, each case would be subject to Scottish Government agreement as part of the Business Case approval process."

You see that?

A Yes.

Q So was your understanding of the position as at 20 July 2010 when you were working on the Edinburgh project----

A Yes.

Q -- a presumption of 100 per cent single beds in a new hospital unless there is a clinical justification for (inaudible)?

A Yes.

Q Lord Brodie, I am conscious that that is just after 1:00 p.m. I do not anticipate being much longer, but I think I would be more than 10 to 15 minutes so that may be an

opportune point to break.

THE CHAIR: Ms McKenzie, will you come back this afternoon?

MS MCKENZIE: Yes, that's fine.

THE CHAIR: You have heard what Mr MacGregor has to say. It may not be for a very long session, but we will take our lunch break and sit again at 2:00 p.m.

MS MCKENZIE: Yes.

THE CHAIR: If you could be back for then that would be great. Thank you.

(Luncheon Adjournment)

14:00

THE CHAIR: Good afternoon, Ms MacKenzie. I think we're ready to resume, Mr MacGregor.

MR MACGREGOR: Thank you, my Lord. Ms MacKenzie, before lunch we were looking at Scottish Government policies on 100 per cent single bedrooms in hospitals unless there's a clinical justification for a departure. In relation to the Royal Hospital for Children and Young People, did you consider that there was a clinical justification for a departure from 100 per cent single bedrooms?

A Yes, I did, as did the clinical teams.

Q Is that for all the reasons that you've said in your statement that we covered before lunch?

A It is, yes.

Q Was that recorded within the business cases for the project?

A It was, yes. So the report that I wrote following the consultation was an appendix, the business case.

Q So if we could perhaps just look at the original outline business case from 2008. That begins in bundle 3, volume 1, at page 272. You will just see there that it's the outline business case, but if we could look on to page 321 within the bundle, please. At page 321, do we see a range of areas set out including single rooms, beds in two-bedded bays, and beds in four-bedded bays?

A Yes.

Q For example, in the grey shading, we'll see that, for critical care, there was always going to – in terms of this business case – be with two and four-bedded bays.

A Yes, at that time. Yes.

Q If we could then look on page 426, please. We see an appendix: "FUTURE SERVICE PROVISION… 6.3 Single Room Accommodation Report". Do you see that?

A Yes.

Q Have you seen that before?

A I have, yes.

Q What is this?

A So this basically is the report that was produced following the consultation that we undertook with families and the children, and also the clinical viewpoint.

Q (To the Judge) Sir, that's bundle 3, Volume 1, at page 426.

THE CHAIR: Thank you.

MR MACGREGOR: And we see that that begins with the introduction:

> "This paper will provide information on the issue of single rooms and bed bays within the proposed new Children & Young People's Hospital in Edinburgh. A recent draft Report 'Single Room Provision in Scotland', produced by NHS Scotland on behalf of the Scottish Executive Nurse Directors Group (March 2007) proposes that all new hospital builds should provide a 100% single room accommodation. This recommendation was made following consultation with patients and nursing staff, however this does not appear to have specifically involved consultation with children, young people and their families and the nursing staff caring for this patient group."

Is that the report that we've already seen earlier today?

A It is, yes.

Q It then goes on to outline that the consultation had taken place. If we look on to page 427, just above "Clinical Staff Feedback", the report stating:

> "Overall from the feedback we have received to date it is being proposed that there will be a minimum of 50% single room accommodation for patients. However it is important to note that the single room accommodation requires to have en-suite facilities. There should also of sufficient space for one parent to sleep overnight with the child/young person."

See that?

A Yeah.

Q Then the final paragraph on that page:

> "Not all parents will stay with their child overnight or are here all the time during the day. Children and many young people often feel very isolated and alone when they are in cubicles and

enjoy the social interaction of being in a ward area beside other children.

In addition younger children and babies, unlike adults, are not able to use nurse call systems and therefore observation of them is more difficult if all were to be nursed in single rooms.

Children as part of their development require social interaction and for those who are unable to mobilise and are confined to their bed and therefore not able to use the playroom, benefit from being nursed beside other children. This is a particular issue for children who are in hospital for a very long time.

100% single rooms would compromise the management of groups of babies and young children with the same infection e.g. bronchiolitis.

At a recent meeting of senior nurses across the U.K… there was discussion about whether there should be 100% cubicles and this was not supported, as it is recognised that children find great comfort from sharing with others, especially when their parents are not with them.

It was recognised that many adolescents would wish to be in a single room for privacy, however equally many of them also wanted to share and that consideration needs to be given in relation to segregation of male and female patients.

In addition it was felt that having a 100% single rooms would require higher patient: nurse staffing ratios because of the dependence of babies and young children on nursing staff, which is different to the dependence and support required by adult patients."

See that?

A Yes.

Q So is that essentially the justification in a clinical sense for a departure from 100% single rooms?

A It was, yes.

Q Thank you. If I can ask you then to look within bundle 4, please, at page 167 and 168. If we could begin at page 168, is that an email from you to Fiona Halcrow dated 25 October 2011?

A Yes, it is.

Q Who is Fiona Halcrow and what was her role in the project?

A So Fiona Halcrow is-- was one

of the project managers. She was the project manager for-- in the Department of Clinical Neurosciences, and she has a nursing background.

Q We see within that email you say: "Hi Fiona This paper was written in September 2007…" Just to be clear, what paper are you referring to there?

A The paper that was the appendix that we've just looked at to the business case.

Q Thank you.

"… whilst it is 4 years old, the views expressed by staff at that time
overall have not changed. We have not done further consultation with children, young people and their families on this issue.

I think the paper is still relevant as we would still want the ability to cohort patient groups. I would suggest that the date the paper was written is acknowledged and if necessary we can say that the clinical staff feedback remains the same."

Do you see that?

A Yes.

Q So did that represent your views as at 2011?

A It did, yes.

Q Effectively, in terms of clinical justifications, nothing had changed?

A Yes, and I had discussed that with the clinical teams, and they were in agreement.

Q If we can look on still within bundle 4, please, but to page 180. So bundle 4, page 180. Is that a document headed up "Rationale for Proportion of Single Rooms within Children's Wards in New Build"?

A It is, yes.

Q Just to explain, what is this paper?

A So this is a paper that we were asked-- as part of the Scottish Futures Trust who were reviewing projects, we were asked to provide the justification why we were not going with 100 per cent single rooms.

Q Do we see, for example, in the second full paragraph, there is an acknowledgement of CEL 48 and CEL 27, which we saw before lunch**.** There is then a table with various beds**.** Then at the bottom of the page, just before the two bullet points:

"There are a number of reasons for not having 100% single rooms within the children's inpatient wards for the new build, which are as detailed below…"

Then there is a range of

justifications included. Do you see that?

A I do.

Q I won't read them all out, but are they essentially the same justifications that we have already seen within the original outline business case?

A Yes, they are.

Q We see that is completed by you, Janice MacKenzie, in January 2012.

A Yes.

Q What was the purpose of this being updated in 2012?

A Because a new business case was to be submitted in 2012 to include the Department of Clinical Neurosciences. So the previous assumptions that had been made in the 2008 outline business case, we were re-looking at them.

Q As you say, in your view clinically nothing had changed in terms of the justifications.

A Yes, in the view of the clinical teams, nothing had changed.

Q That obviously deals with the Royal Hospital for Children and Young People. What about the Department of Clinical Neuroscience? Was that to have 100 per cent single beds?

A That was to have 100 per

cent single-bed rooms and that was how it was planned. However, the clinical teams within the Department of Clinical Neurosciences had concerns about that from the point of view of their most critically ill patients. So they looked at the reasons for that and a paper was written to propose that they had two, four-bedded bays and that was led by Fiona Halcrow, the project manager and James Steers, who was the clinical lead.

Q You are obviously aware of that, but were you involved in that aspect with the Department of Clinical Neuroscience?

A I wasn't involved in the discussions with the clinical teams. As I say, that was led by the two individuals that I said, but I was asked to review the paper before it was submitted.

Q And just so that we are clear on the paper we are talking about, if we can look at bundle 4, please, at page 182. Is that the derogation paper that we are----?

A Yes.

Q In relation to support from the chief medical officer, are you aware of whether the chief medical officer supported the recommendations in relation to departing from 100 per cent single-bed

rooms?

A Yes, I was aware that he had supported it.

Q Were you involved directly in those discussions?

A No, I wasn't.

Q In relation to the design of each ward, thinking particularly about the Royal Hospital for Children and Young People, were you involved in discussions in relation to single-bed rooms and multi-bed wards and specifically where they should go within the hospital?

A I was, yes.

Q What was the nature of the discussions that you had?

A So the nature of the discussions were based on the clinical specialty for each of the ward areas, the types of conditions that were within them, the age range of the patients and their clinical needs.

Q Who did you discuss this with?

A They were discussed with each of the clinical teams for each of the ward areas, so that would be the medical staff, the nursing staff and the allied health professionals.

Q How were those views conveyed to the design team?

A They were conveyed in that we gave them a detailed

breakdown of each ward: the number of beds; the number of single rooms there were to be; the number of isolation rooms; and the number of four-bedded bays.

Q After that information had been conveyed, did you have any direct discussions with the design team?

A I would have been involved in discussions with the architects around how the wards were going to be laid out from the point of view of the actual-- whilst we had decided on the number of single rooms and four-bedded bays, but in what configuration would they be in and what support accommodation would be around them.

Q To be clear, in terms of the design team, your discussions were with the architects only?

A Yes.

Q I just want to ask you a few questions about technical requirements for the new hospital. At any point during your involvement in the project, did you discuss a ventilation strategy?

A No, not directly.

Q Did you ever discuss it indirectly?

A Not as such. I mean, I was obviously aware that there were

SHTMs and we were, on occasions, asked by technical advisers for clarification around the type of patient that might be within a ward area and that was obviously to do with many of the technical aspects.

Q Were those discussions of a general nature?

A Yes. So they would be about, “Are the patients in this area, are they oncology patients?” That type of thing.

Q Thank you, Ms MacKenzie. I do not have any further questions, but his Lordship or-- there might be other applications.

THE CHAIR: Again, did something arise from Ms MacKenzie's evidence that anyone wishes to take forward? Again, I will take that as a no. Ms MacKenzie, that means that is the end of your evidence and thank you very much for coming and providing it. You are now free to go. Thank you.

THE WITNESS: Thank you.

(The witness withdrew)

THE CHAIR: Now, Mr MacGregor, that is your witnesses for today, am I right?

MR MACGREGOR: No, my Lord. There is also Mr Edward McLaughlan.

THE CHAIR: Of course. Mr McLaughlan, yes. Right, we will probably take no more than five minutes, but it might be just a little bit more than five minutes, so we will rise.

14:15

(Short break)