Scottish Hospitals Inquiry

Witness Statement of

Mary Morgan

Introduction

1. My name is Mary Morgan. I am currently employed as the Chief Executive of NHS National Services Scotland (NHS NSS). I was appointed to this post on 1 April 2021, succeeding my predecessor, Colin Sinclair. I was appointed, by the Scottish Government, as the Senior Programme Director (SPD) for the Royal Hospital for Children and Young Persons and Department of Clinical Neurosciences (RHCYP/DCN) project on 16 September 2019. My appointment as SPD ended on 13 April 2021 **(A46527622 - Letter from Richard McCallum dated 13 April 2021 – Bundle 13, Volume 3 – Page 701)**.

2. In this statement I address the following:

   a. Professional qualifications and background.
   b. Appointment as SPD in respect of the RHCYP/DCN Project.
   c. My experience of the Non-Profit Distribution (NPD) Finance Model.
   d. My role as SPD with particular focus in relation to:
      i. Initial Activities and Key Relationships
      ii. Delays – the NPD Model and Covid
      iii. Concerns related to the hospital building
      iv. Remedial Works – Ventilation
      v. Other Remedial Works – General
      vi. The phased migration to the new hospital buildings.
   e. Governance and Reporting
      i. The Oversight Board
      ii. Senior Programme Directors' Report
      iii. Executive Steering Group
      iv. NHS Lothian (NHSL) Board Meetings

v. Strategic Liaison / Contract Review / Delivery Groups / Commercial Subgroup
vi. The Cabinet Secretary.

f. Escalation and De-Escalation – Level 4.

g. The Royal Hospital for Sick Children (RHSC) at Sciennes Road, Edinburgh and the Department of Clinical Neurosciences (DCN) at the Western General Hospital, Edinburgh; and

h. Some of my reflections from my time as SPD.

Professional Qualifications and Background

3. I started my career in the health service in the delivery of clinical care, working as a staff nurse and, ultimately, a ward sister at the Western Infirmary in Glasgow between 1985 and 1996. I moved into nursing management and then into general management with the then, NHS Argyle and Clyde Health Board, between 1996 and 2006.

4. Between 2006 and 2008 I was the General Manager of Emergency Care and Medicine at NHS Greater Glasgow and Clyde. As the General Manager for Emergency Care and Medicine, I was responsible for service delivery in those speciality areas in the Royal Alexandra Hospital, Paisley, Inverclyde Royal Hospital, and the Vale of Leven Hospital in Alexandria.

5. In September 2008, I moved to NHS National Services Scotland (NHS NSS) as the Director of Health Protection Scotland. As Director of Health Protection Scotland, I directed and managed a diverse, highly specialised team of clinical and managerial staff tasked with delivering effective and specialist national services which coordinate, strengthen and support activities aimed at protecting the people of Scotland from infectious and environmental hazards, in line with objectives set by the NHS NSS Board and Scottish Government Health Directorate directives.

6. I held this post until January 2012 when I became the Director of the Scottish National Blood Transfusion Service where I was primarily responsible and

accountable for ensuring the collection, manufacture and supply of high quality blood components, tissues and cells, and for the provision of some highly specialised clinical services, to meet the emergency and elective needs of Patients in Scotland, within statutory and regulatory requirements; including compliance with the Blood Safety and Quality Regulations 2005, as amended, and the Human Tissue (Scotland) Act 2006.

7. I became the Director of Strategy, Performance and Service Transformation on October 2018, a post I held until I became Chief Executive of NHS NSS in April 2021. The Director of Strategy, Performance and Service Transformation is a corporate role within NHS NSS responsible for providing:

- Strategic Leadership which is instrumental in positioning NHS NSS as a trusted partner and centre of expertise in transformational change, shared services, portfolio management and programme delivery
- Leading and directing specific corporate programmes to support NHS NSS in the discharge of its governance responsibilities and optimal operational delivery across NHS NSS' businesses.
- Direct responsibility for the delivery of National Transformation Programmes.

My role as Director of Strategy, Performance and Service Transformation allowed me to maintain a portfolio of different projects. As I explain below, it was during this time that I was appointed as SPD to the RHCYP/DCN project.

8. In April 2021 I was appointed as the Chief Executive of NHS NSS. As the Inquiry is aware, NHS NSS is a non-departmental public body established under s10 of the National Health Services (Scotland) Act 1978. NHS NSS is constituted by a number of distinct departments who are responsible for the delivery of specialist services and support to the NHS in Scotland. As Chief Executive I am responsible for the strategic management and oversight of NHS NSS' various departments and the organisation as a whole.

9. I hold the following academic qualifications:

- Master's Degree in Health Services Management from Kings College in London 2003
- BA Service Sector Management, Glasgow Caledonian University – 1995
- HNC in Management, Stow College, Glasgow – 1993
- NBS Diploma in Professional Studies, Western College of Nursing and Midwifery, Glasgow – 1988
- Registered General Nurse, Western College of Nursing and Midwifery, Glasgow, 1985.

Appointment as Senior Programme Director and Initial Steps

10. It may be helpful for the Inquiry to consider the context within which my appointment as SPD was made. On 4 July 2019, the Cabinet Secretary for Health and Sport, Jeane Freeman, postponed the planned move of patients and staff from existing facilities to the newly constructed DCN/RHCYP buildings. On 12 July 2019, Malcolm Wright, Director General (DG) Health and Social Care, advised NHSL that they had been escalated to level 3 of the Scottish Government's Performance Framework **(A41263551 – Letter to Tim Davison, copying in Brian Houston, from Malcolm Wright – 12 July 2019 – Bundle 7, volume 1 – Page 339)**. This escalation meant that NHSL would be provided with a tailored package of support with a view to improving performance. In July 2019, the Cabinet Secretary and the DG of Health and Social Care appointed an Oversight Board in relation to the RHCYP/DCN project. The purpose of the Oversight Board was to provide advice and assurance to Ministers that the RHCYP/DCN project would be delivered efficiently and safely. The first meeting of the Oversight Board took place on 8 August 2019. On 13 September 2019, Malcolm Wright advised NHSL that, in respect of the RHCYP/DCN project, they had been escalated to level 4 of the Scottish Government's Performance Framework. My appointment as SPD, effective from 16 September 2019, was part of the additional support accompanying that escalation **(A44267042 - Letter - MW - B Houston and T**

Davison – NHS Lothian Level 4 Escalation - Sept 2019 – Bundle 13, Volume 3 – Page 702).

11. I was first contacted about the SPD role August 2019. I can't remember the exact date but I think it was towards the end of August 2019. I was telephoned by Christine McLaughlin who was, at that time, Chief Finance Officer NHS Scotland and Director of Health Finance, Corporate Governance and Value (a Scottish Government Health Directorate). Christine explained that the Scottish Government wanted to appoint an SPD in relation to the RHCYP/DCN project. Christine asked if I was interested in the role and advised that I had been identified as a suitable candidate because of my background and experience from, amongst other things, delivery of the Jack Copland Centre (JCC) while I was Director of the National Blood Transfusion Service (discussed further below).

12. Christine told me that NHSL had been escalated within the Performance Escalation Framework and that the Cabinet Secretary was seeking to appoint somebody into a senior role to provide them with the support required of escalation. Christine advised that, if I was interested in the role, she would require to confirm that my credentials etc, were to the satisfaction of the Cabinet Secretary, and that a formal letter of appointment would follow. It was explained to me that, in essence, the role was to provide support; to work within NHSL and its governance structures; to facilitate the completion of remediation works at RHCYP/DCN and to provide assurance that the building would open safely and was fit for occupation. All other actions relating to the existing sites and the service migration to the new facility would remain the direct responsibility of NHSL.

13. Following my call with Christine and after giving the matter some thought, as well as discussing the role with the then Chief Executive of NHS NSS, I advised Christine that I would be interested in the role. Thereafter, the Cabinet Secretary approved my appointment effective as of 16 September 2019. I received a formal letter of appointment from the Scottish Government, dated 23 September 2019 **(A46527599 - Letter from Christine McLaughlin to Mary**

Morgan – 23 September 2019 – Bundle 13, Volume 3 – Page 704). This letter explains:

"This appointment forms part of the tailored support to NHS Lothian as part of the escalation to Level 4 of the performance framework for this programme, to strengthen the management and assurance arrangements for completing all of the outstanding works necessary to open the facility. The appointment formally commenced on Monday 16 September and will be reviewed on a rolling quarterly basis. During the period of this appointment you will remain an employee of NHS National Services Scotland and retain your existing terms and conditions and will report to the Chair of the Oversight Board.

In your role as Senior Programme Director you will have responsibility for the actions to ensure that the facility is fit for occupation and I expect you to work as part of the NHS Lothian team. All other actions relating to the existing site and to the service migration to the new facility, will remain the direct responsibility of NHS Lothian".

Prior Experience of the Non–Profit Distribution Model

14. When I joined the Scottish National Blood Transfusion Service, in January 2012, it was preparing to procure its new building: The Jack Copland Centre (JCC). The JCC is the national centre for the Scottish National Blood Transfusion Service, providing blood, tissue and cell manufacturing and testing facilities for Scotland. It is a Good Manufacturing Practice (GMP) facility providing pharmaceutical grades D, C, B and A manufacturing environments. Its functions and facilities require to meet stringent regulations and are inspected by the Medicine and Healthcare Regulatory Agency and Human Tissue Authority. Like the RHCYP/DCN, the JCC was procured as an NPD project. As far as I am aware, the JCC was the first NPD healthcare project to commence and, I believe, to conclude in Scotland.

15. Procurement and construction of the JCC, and the successful transition of services into the building was one of my major objectives as director of the

National Blood Transfusion Service. I directed that NPD programme from procurement through to completion and commissioning of the new facility.

16. Public Private Partnerships had been used to deliver public sector infrastructure across Scotland before the JCC, but not via the NPD model. Because the NPD model was new, all parties involved in the project were, to some extent, finding our way as the JCC was procured, constructed and commissioned. For example, prior to the JCC I had not been involved in procurement by competitive dialogue. Further, the NPD model is based on a standard form contract developed and controlled by the Scottish Futures Trust (SFT). While SFT provided support throughout the project as regards their standard form contract and commercial matters related thereto, that did not remove the complexity occasioned by the use of an entirely new commercial agreement.

17. As with all complex healthcare projects, the JCC was delivered by a project team including a project director who had a team of staff which included a range of technical and legal professionals, NPD and technical advisors. However, as Director of the National Blood Transfusion Service, I was ultimately responsible and accountable for delivery of the project reporting to the Chief Executive of NHS NSS at that time. The JCC project gave me direct experience of managing an NPD project with complicated, complex and stringent technical requirements, including those of ventilation and temperature control. This experience was directly transferrable to the role of SPD on the RHCYP/DCN.

My Role as Senior Programme Director

18. My role as SPD is as set out in the Scottish Government's letter dated 23 September 2019. In essence, the role was to support NHSL to deliver the RHCYP/DCN safely and effectively. I reported to the Oversight Board Chair, initially Christine McLaughlin and then, by Nov 2020, Professor Fiona McQueen, Chief Nursing Officer. I submitted reports, the Senior Programme Director's Reports, to the Oversight Board. These reports accurately reflect the work that I was doing in performance of my SPD role. I also attended the

meetings of the Oversight Board and contributed to those meetings where appropriate and required to do so.

19. My role was, in essence, to work with the DCN/RHCYP Project Team (Project Team) including Integrated Health Solutions Lothian (IHSL) and its partners to achieve safe and efficient delivery of the project. This included addressing the issues that had been identified with the ventilation systems in the critical care unit at the RHCYP as well as addressing the matters identified in the NHS NSS review of water, ventilation, drainage and plumbing systems, dated 9 September 2019.

20. I acted as the interface between NHSL, the Project Team, Scottish Government (either Christine McLaughlin or Fiona McQueen via the Oversight Board), NHS NSS (my own organisation), including Health Facilities Scotland (HFS) and Antimicrobial Resistance & Healthcare Associated Infection (ARHAI) Scotland: a clinical service providing national expertise for infection, prevention and control (IPC), antimicrobial resistance (AMR) and healthcare associated infection (HAI) for Scotland. As part of my 'interface role', I brokered and improved communication between NHSL and the NPD provider, IHLS. The commercial relationship and negotiations between these parties were challenging and I feel that I made a positive difference to these.

21. NHS NSS provided the Oversight Board with advice and also undertook the technical review of the six areas identified by them as potentially requiring remediation: Drainage, Water, Ventilation, Fire, Electrical and Medical Gases. I worked within NHS NSS and had the organisational knowledge, 'know how', and close professional relationships with the teams and individuals therein providing strong foundations for me to add value to the interface between the RHCYP/DCN project and NHS NSS.

22. In very simple terms, I was making sure everyone was doing what they were supposed to be doing, when they said they were going to do it by and ensuring that all parties were accountable for their own actions. The purpose of this was

to keep the project and required actions on track and to ensure that any proposed delays were properly interrogated.

Initial Activities and Key Relationships

23. One of the first things I did was meet with Brian Currie and the rest of the NHSL Project Team. They were working from the project office based at the Little France site. This location was very positive because it meant that they were already in that space and could experience the building first hand. IHSL, Bouygues and Multiplex also had space in the hospital, and it was good that all parties were, physically, working quite closely together, although in somewhat separate accommodation. Most meetings in relation to the project site were held in meeting rooms onsite.

24. I started to participate in the meetings and hear what was happening. The Project Team was, at that time, quite depleted. I recall that some members had planned to retire after the hospital opened. Some of those who had planned to retire delayed doing so but others did not and were no longer available to support delivery of the project. Other members of the Project Team had already been redeployed to other work.

25. Unsurprisingly, the general mood of the Project Team was low. I wouldn't go as far as to say that the team was demoralised, however, the general atmosphere was 'muted'. The team was slightly uncertain about what my appointment meant for them and what they were to face. I was, however, very clear that they needed to keep performing their existing roles and to keep me informed as they did so. This allowed me to understand their roles and project status. I hope I dispelled any fears they may have had early in my appointment.

26. NHSL's technical advisers, Mott MacDonald, were based in the same space as the NHSL Project Team (in essence, as part of that team). I found this to be a very helpful arrangement which facilitated the communication of good technical advice combined with good project intelligence and shared knowledge across all relevant persons.

27. At the outset, we were particularly reliant on one of NHSL's commissioning managers, Ronnie Henderson. I asked for more staff because I believe he was overwhelmed by the amount of work that he needed to do and that which was forthcoming. It took a little bit of time to secure the additional people resource needed for the project and they really made a difference when they joined.

28. The other thing that I recognised was that there was a plethora of action plans and snagging lists. Some of the action plans were duplicates of previously identified work that was already underway or actions that were outstanding. There were also action plans coming out of the technical reports undertaken by NHS NSS as well as additional or emergent actions arising as works progressed on site. I ensured that the various action plans were combined for greater visibility and control to ensure there was clarity over what action was to be taken, by when and by whom. I asked Mott MacDonald to create a dashboard reporting tool to be able to track delivery against expectation and to document/record evidence of completion/outcome. Action plans were combined and duplication removed so we worked off single action plans for each of the six technical review areas: Drainage, Water, Ventilation, Fire, Electrical and Medical Gases.

29. With regard to relationships, everybody was very professional and welcoming towards me. Brian Currie and the Project Team were very keen to show me what had been achieved. It was difficult to assess the relationship between NHSL and IHSL other than to say it was of a commercial nature.

NPD Contract

30. IHSL was the Project Company under the NPD contract. IHSL contracted Multiplex to construct the hospital and Bouygues as the Facilities Management (FM) provider. The role of the FM provider is to maintain and manage the facility once it is constructed. This is regulated by an agreement between Project Company and FM provider. Bouygues, as FM provider, had certain contractual responsibilities to undertake rectification works (discussed below).

There was some resistance from Bouygues to some of the works they were asked to undertake. In short, they were concerned that some of the medium to high value rectification work they were being asked to undertake was not cost-effective for them in consequence of the payment mechanism that had been agreed with them.

31. Early in my period of appointment, I visited the Royal Hospital for Sick Children, Sciennes Road, Edinburgh and the Department of Clinical Neurosciences, Western General Hospital just to see what the facilities were like at those hospitals.

Delays – The NPD Model and Covid-19

32. The Inquiry has asked me about complications and delays that arose during my time as SPD. In particular, I have been asked whether the NPD model complicated matters or held up the job that I had to do.

33. My role was to oversee the delivery of a major healthcare construction project. Such projects are, by their very nature, complex. The RHCYP/DCN project was developed and delivered over a number of years before I became involved. That, however, did not diminish the level of technical and commercial complexity of the parts of the project in which I was engaged.

34. The NPD model, as a model of Public Private Partnership (PPP) finance, meant that more parties were involved in decision making than if the project had been delivered as a capital build project by NHSL. In particular, the involvement of investors who were funding the build through IHSL, increased the range of commercial interests that had to be taken into account and accommodated during decision making processes. This meant that a lot of the negotiations that we had were quite commercial in nature. I don't know if this made matters more complex than they would have been had the project been a capital build as I can only comment on the facts and circumstances that were presented in my role as SPD.

35. I don't recollect, during my time as SPD, thinking that things might have been easier were we not working within the NPD finance model. The NPD finance model is what we had to work with. I would, however, reflect that the NPD finance model is very commercial in nature: private finance would not involve themselves in NPD projects if it was not financially sensible for them to do so. In my opinion this resulted in a lot of decisions being determined one way or another based on the parties' assessments of commercial risk. Such assessments are, of course, multi-faceted and were often matters which the parties' senior decision makers required to determine. At times, that caused me to reflect that while negotiations were undertaken between those who are 'on the ground' those persons were not always the decision makers. This, perhaps, prolonged decision making as decisions reached during negotiations still required to be ratified by senior decision makers, for example, by IHSL's funders.

36. On 17 September 2019 the Cabinet Secretary for Health and Sport announced that a public inquiry would be held in relation to, amongst other things, the delayed opening of RHCYP/DCN. The announcement that a public inquiry would be held added a level of complexity to commercial negotiations. I don't know if this resulted in any delays, but it seemed to create an additional level of anxiety amongst the commercial parties involved in delivering the RHCYP/DCN project. I think those parties saw the presence of a public inquiry that was likely to scrutinise their actions as an increased commercial risk to them. This applied to the appointment of external suppliers too.

37. At times, parties would approach me to discuss the prospect of a public inquiry. I think that some thought that I would know more about it than they did because I had been appointed by the Scottish Government but I didn't know any more than anyone else. These discussions did, however, allow me to form my views related to increased levels of anxiety. I mention this simply as a matter I consider relevant to my observations related to the commercial decision making process I have described above. I am, in no way, being critical of the Cabinet Secretary's announcement or the important work being undertaken by the Public Inquiry.

38. I have no doubt that the onset of Covid-19 had an adverse impact on the project timeline. Although the Project Team and contractors kept working through lockdown (the RHCYP/DCN project was considered a critical infrastructure project), delays were caused by socially distanced working practices and supply chain issues arising as a direct consequence of the pandemic. Covid-19 meant that Imtech (the supplier of the remedial ventilation systems for the Critical Care Unit of the RHCYP) had to work harder to locate and to source materials because the supply chain was impacted. Delivery of goods and supplies did not arrive when expected. People had to work socially distanced so more detailed risk assessments and safe systems of work had to be undertaken.

39. I visited the hospital site and Project Team about once a week throughout the pandemic to maintain visibility. Working remotely, for example for meetings, was largely new to many of us and was unreliable in early stages.

40. However, as well as causing problems for delivery of the project the pandemic also provided an increased impetus to get as much of the hospital up and running as soon as was possible, to meet the increased demand on health services that was anticipated to arise in consequence of increased admissions to hospital as well as the need to maintain social distancing on other wards across the healthcare estate. While construction was ongoing in areas of the hospital, other areas were able to be used to provide a solution as part of the Covid-19 response. For example, out-patients were moved into the new building because additional space was needed for social distancing; The Ronald MacDonald House accommodation was used to house staff who could not return home; Covid-19 vaccination clinical research was undertaken in one of the wards. It felt good to have some parts of the building in use and to be able to demonstrate the success of a phased approach to using the building. I discuss phased migration in greater detail later in this statement.

41. One of my reports highlighted this perfectly when we went from Green to Amber. There was a critical resource issue arising, with an entire specialist team being affected by Covid-19. **(A40933361- Oversight Board Papers – 14**

January 2021 – Bundle 3 – Page 1077). I'm just using that to exemplify the types of issues that needed managed in terms of delay events for the project due to Covid-19.

Building Concerns

42. I have been asked by the Inquiry what were the main concerns with the project at the time of my appointment. When I was first approached by Christine McLaughlin about taking up the role of SPD I understood the principal area of concern to be defective ventilation in the Critical Care Unit. I understood that the number of air changes fell below the standard required by relevant SHTM guidance. At that stage, I did not appreciate that Health Facilities Scotland were undertaking additional investigations in relation to water, ventilation, drainage and plumbing systems or that subsequently, the second three areas for technical review: medical gases, electricity, and fire.

43. At that time, and primarily based on my experiences with delivery of the JCC, I had a general understanding of the guidance relevant to ventilation in Scottish healthcare environments. By that, I mean that I knew there was guidance applicable to ventilation systems and where the relevant SHTM could be reviewed. However, questions as regards the technical interpretation and application of that guidance are matters upon which I would draw upon experience from appropriately skilled technical colleagues. In the case of the RHCYP/DCN my understanding was that the air handling units did not provide sufficient air changes. Fundamentally, that needed to be remediated.

44. We had a similar, albeit not so serious, issue with the air handling units at the JCC whereby there was, initially, insufficient capacity in the air handling units to provide resilience and the units that had been installed had to be swapped for ones with bigger motors to achieve the requisite air changes and ventilation cascades.

Rectification Works – Critical Care Ventilation

45. As I explained above, Bouygues are the FM service provider for the RHCYP/DCN. Their engagement is triggered by practical completion of the project: when the construction phase comes to an end and a facility is available to manage. The Practical Completion Certificate for the RHCYP/DCN was issued on 22 February 2019.

46. Once practical completion had been achieved, Bouygues had expected to be working in a fully functioning hospital and they weren't. They were receiving payment but felt that the deductions they were experiencing because the hospital was not operational served as punitive penalties. There were many disagreements about the payment mechanism and the deductions made. Against this background, Bouygues didn't want to take on board the rectification works without re-drafting their agreements with IHSL to make it economically viable for them to do so. I recall meeting with a Bouygues Director, and she said, "No, we're not going to do this" and that while in terms of their contractual obligations they are responsible for undertaking any changes to site, their argument was that Multiplex was still on site and still had work to do. They took the view that Multiplex should be responsible for undertaking rectification works – this was not Bouygues' responsibility.

47. Multiplex was responsible for constructing the hospital. Practical completion had been achieved, and the hospital had been accepted. They did not consider that undertaking the remedial ventilation works was their responsibility. Accordingly, if they were to undertake the remedial works, they believed that this would be formalised in a supplemental agreement to their original contract.

48. I joined Susan Goldsmith and the team in the negotiations about facilitating the rectification works and finding contractors who could do the work. Those negotiations were difficult and Susan, Matt Templeton (IHSL Director) and I all worked hard to deliver a practical solution that resulted in the rectification work being undertaken, but it would be misleading to describe that process as anything other than difficult and challenging. Neither Multiplex nor Bouygues

were going to do the works. Susan Goldsmith and I had been considering if and when NHSL should 'step in', as per their agreement with IHSL, when Matt Templeton came up with an alternative solution, to be supplied by Imtech, on the basis of a standard NEC 4 design and build contract. I recollect that Susan Goldsmith and I were quite surprised by the sudden nature of this development. Matt Templeton said he had not advised us sooner as he had not wished to raise hopes. Nevertheless, all three of us were delighted that a potential solution had been identified.

49. Imtech had considerable experience in hospital settings and was the only contractor that had been identified who were willing to undertake the work. My feeling at the time was that the public focus on the rectification works probably put some contractors off: I certainly wasn't aware of many suppliers who had expressed an interest in doing the works. I don't know if that is, in fact, what happened but it was the impression I formed at the time.

50. Having identified that Imtech could undertake the works it was then necessary for NHSL to enter into a supplemental agreement with IHSL in relation thereto. This required to be agreed and negotiated between the parties. Negotiating that Supplemental Agreement (SA2) became a significant part of the project. A lot of the concerns and negotiations related to warranties. If we were going to modify the ventilation system or put something new in, who was going to warrant that work.

51. Supplemental agreements are in some ways not supplementary. They are, in essence, new contracts that are layered on top of an existing agreement. They come with associated additional costs. SA2 involved rewriting components of the pay mechanism that had already been agreed between NHSL and IHSL, and there were lots of meetings with lawyers with lots of negotiation on this point. These took a lot of time. My challenge was what work could progress while SA2 was being negotiated? Can we progress with some design work? Can we progress with actual works at all, without actually breaking the warranty terms ahead of SA2 completion?

52. There was some design work that Imtech were able to undertake pending finalisation of SA2. However, Imtech could not be contractually bound to undertake the full works until SA2 was agreed so there was a limit to what they could reasonably be instructed to undertake, without the guarantee that they would be instructed to undertake the full program of rectification works. Earlier in this statement I described that the NPD model is very commercial with each party having distinct commercial interests. Imtech, as a supplier operating in that model were another party who required to consider and protect their own commercial interests and liabilities.

53. The Inquiry has asked me if I have any concerns that agreement of SA2 delayed the project more than anything else. Commercial negotiations were a major factor that impacted on the timeline, but I don't believe it was just that, there were other factors. Firstly, the initial target date for completion of rectification works was set before the full knowledge of what rectification works were required. Once the NHS NSS reviews had been completed, it was clear that there was more work to be done beyond undertaking the necessary remedial works to the ventilation systems in the Critical Care Unit. These works had not been accounted for in the initial estimated completion deadline. Secondly, additional remedial works were identified as the programme of works progressed. The fact that the hospital was not occupied provided the opportunity to do the works at that time when, otherwise, they may have been undertaken as a programme of general maintenance. Thirdly, and most significantly, the Covid-19 pandemic was the biggest single factor impacting upon the project timeline.

Additional Remedial Works – General

54. Apart from the number of air changes being deficient, the technical review of ventilation and other matters undertaken by NHS NSS identified a number of other matters to be remedied and rectified.

55. In terms of water and its testing, there was learning from the Queen Elizabeth University Hospital Campus, Glasgow (QEUH), especially where gaps in formal guidance were evident. There were times when professionals disagreed about what was required to be done if anything. When there was disagreement, time was taken to discuss, secure professional consensus and to agree actions. An example of this related to whether it was necessary to strip down and inspect the taps installed at the hospital. HFS were concerned that the taps may have become corroded and contaminated. I understood HFS' concerns were derived from work they had undertaken at the QEUH. HFS wanted all of the taps to be stripped back and examined. NHSL did not agree that this was necessary. I recall that HFS' position was not supported by technical guidance and their learnings from the QEUH were continuing to develop. For my own part, I agreed with NHSL. In the end, after detailed discussion and dialogue between HFS and NHSL, agreement was reached that it was not necessary to strip down and inspect the taps at the RHCYP/DCN. This issue was not escalated to the Oversight Board as the professionals tasked with delivering the project were able to agree a safe and sensible way forward.

56. There was an issue with the patient baths supplied by Arjo. The baths were found to be contaminated with pseudomonas, possibly related to a manufacturing contamination. Arjo removed the baths, disinfected them offsite and moved them back in again.

57. The electrical issues identified by NHS NSS were mainly related to supplying evidence of safety. The requisite evidence demonstrating that the electrical systems, mainly in theatres, met requirements was produced. I don't recall there being very much by way of rectification work that needed to be done for electrical safety.

58. The fire safety technical review made a number of recommendations. The main issue was the lack of fire dampers within the ventilation system. The main question was the definition of the hospital wards/rooms as "sleeping accommodation", and the requirements of extant guidance. It was the area of

greatest debate at the time. I do not believe this question was ever really answered satisfactorily for this project but it became a moot point as the decision was made to undertake improvements to fire safety through the installation of fire dampers in all ward areas. There was a concern that the installation of fire dampers would reduce obstruct ventilation flows, but this was not realised.

59. The installation of fire dampers requires these to be inserted into the ventilation ducts. The intent is that spread of smoke, fire, or both, through the ventilation ducts would be dampened and there would be greater time for evacuation. As a result of fire damper installation, the ventilation system needed to be retested to ensure there had been no adverse impact on the ventilation system.

60. For medical gases, the recommendations of the technical review were in relation to commissioning the systems by the appropriate pharmacists prior to opening.

Phased Migration

61. I was keen that there was a phased opening to the building. The public purse was paying for the building that wasn't being used, and I always felt that it was important to get it occupied as soon as it was safe to do so. Further, the facilities at the RHSC at Sciennes Road and the DCN at the Western General Hospital were suboptimal for the delivery of modern healthcare. Phased migration was not, however, straightforward and particular regard had to be had to NHSL's ability to clinically resource any part of the building that was opened.

62. Initially, I sensed reluctance to consider a phased opening of the hospital. I don't think anyone was ever overtly against the possibility and there was a willingness to have exploratory conversations.

63. There was resistance from clinical teams about dividing their places of work and existing clinical adjacencies. For example, the Child and Adolescent Mental Health Service (CAMHS) is essentially a stand-alone service within the

hospital. However, when they need help, they need it from the rest of the Children's Hospital. So, if there is a clinical emergency or an incident that takes place, then they needed to have other staff who would come in to support them in their area. Whilst CAMHS is independent, they could not be isolated from other mechanisms of support and that, for them, was a no-go position.

64. The "game changer" for phased use of the building was Covid-19. Additional space was required across the NHS estate to allow for continuity of services while maintaining and accommodating the need for social distancing. I recall attending a meeting where Tracey Gillies, NHSL Medical Director, brought forward the proposal that perhaps the situation anent phased migration had changed with the on-set of Covid-19 and thus, the driver for change towards phased migration became the preferred option.

65. The phasing of migration was not in my remit (see my terms of appointment discussed at paragraph 18 above). The migration planning and execution were all for NHSL to deliver. I was constrained to ensuring that the new building was fit to occupy, including any parts that were to be occupied in a phased manner.

66. As the project progressed there were areas of the hospital that were or became fit to occupy ahead of other areas. Outpatient and diagnostic services of the DCN were the first to migrate, which was within a year of the decision to delay the opening of the hospital.

67. At a meeting of the Oversight Board on the 9 April 2020 **(A40933361 – Oversight Board Papers – 9 April 2020 – Bundle 3 – Page 909)** there was discussion surrounding the recommissioning of ventilation systems being completed for all DCN areas and that general areas will be completed in the next three weeks. The original ventilation non-compliance was in the Children's Intensive Care Unit and Haemato-Oncology. DCN ward areas, served by their own air handling unit, were unaffected until fire dampers were installed requiring the ventilation system to be recommissioned. There were no

ventilation issues within theatres, other than the air pressures were a bit high causing some door closure difficulties that needed resolved.

68. The rest of the DCN complement moved in July 2020 **(A40933361 – Oversight Board Papers – 18 June 2020 - Bundle 3 - Page 1005)**. There would also be a move of non-inpatient elements, including outpatient services, to the RHCYP.

69. The phased approach to occupation allowed clinical teams to gain confidence in the building and its facilities. In my opinion, phased opening was a good opportunity to test the building and to iron out any issues that there may be. Clearly, when you move into a new building, you're going to have things that the staff are going to find that are not quite right, that are not where they need to be, these kinds of things. From their point of view, it would be better to have that phased and to let it work, or have things changed as necessary. Another factor for me was that the new facility is far superior to what people were already working in and where patients were receiving treatment, at the RHSC at Sciennes Road and at the DCN at the Western General Hospital.

70. Around January 2021, NHSL decided that as all works were complete and that sufficient services were available then CAMHS could migrate over to the new building **(A40933361 – Oversight Board Papers – 14 January 2021 – Bundle 3 – Page 1083)**.

71. By 24 February 2021 I was able to report to the Oversight Board that apart from general snagging work all ventilation and other significant remedial works had been completed (reference SPD report of same date) **(A40933361 – Oversight Board Papers – 25 February 2021 – Bundle 3 – Page 1091)**. At that point, I was satisfied that, in accordance with my remit as SPD, the hospital provided a very safe modern environment for the delivery of health care services. The hospital fully opened shortly thereafter on 23 March 2021. **(A40933361– Oversight Board Papers – 8 April 2021 Bundle 3 – Page 1096)**.

Oversight Board

72. I attended meetings of the Oversight Board but was not a member. It was the members of the Oversight Board who made decisions. I would make recommendations to the Oversight Board but the board would determine whether these recommendations would be accepted. The Oversight Board was chaired initially by Christine McLaughlin, but then moved to Fiona McQueen, Chief Nursing Officer by November 2020. Details of membership and attendees can be found within the Oversight Board's terms of reference.

73. Colin Sinclair, the Chief Executive of NHS NSS was a member of the Oversight Board. Gordon James, Director of Health Facilities Scotland and Professor Jacqui Reilly, who was the HAI executive lead at NHS NSS and internationally recognised for her expertise in Infection Prevention and Control, attended meetings of the Oversight Board. This meant that the matters I was reporting to the Oversight Board on were being scrutinised by senior members of my employer: NHS NSS. At times, this was difficult as I didn't always agree with, or like, what my peers and NHS NSS colleagues would say or recommend. However, this additional assurance and expertise was obviously of considerable value to the safe and effective delivery of the project.

Senior Programme Director's Report

74. As I explained earlier in this statement, I submitted a Senior Programme Director's report for consideration at meetings of the Oversight Board. The style for this report came from Programme Management Services, a department of NHS NSS. I asked Programme Management Services for a range of report templates, and I chose the one best fit for the reporting I required to do for the project.

75. The report provided a general update on, for example, high level progress against the design and build targets, commercial negotiations and any other factors impacting upon the overall status of the project. The report also reported any mitigating actions to correct project timeline excursions and

provided a status report against each of the six areas of technical review including RAG (red, amber, green) status and narrative report. The report evolved over time to include:

i. delivery against critical path actions and key achievements, highlights, or both, since the previous Oversight Board and key challenges, activities, or both, for the next period.
ii. project risks as included in NHSL's Datix (risk management) system; and
iii. A strategic action tracker was also included once actions had been collated to single action plans.

76. The intention of my report to the Oversight Board was to provide a consistent factual record of progress and ensure the most up to date position was provided for the purposes of assurance and informed decision making. There were aspects of my report that were uncomfortable, especially where activities took longer to resolve than anticipated or problems seemed intransigent. For example: the length of time to agree supplemental agreements and the time to resolve shower hose non-compliance.

Executive Steering Group

77. The Executive Steering Group comprised members of NHSL's executive management team and members of the Project Team. The Steering Group was established prior to my appointment. I would describe meetings of the Executive Steering Group as being tactical in nature: Decisions were made across a range of activities in respect of RHCYP/DCN: progress at the new site, what was also happening by way of the old hospital sites to maintain services, to plan for relocation whenever that would happen and the Covid-19 response. It was a weekly check-in about what was happening with all things across the NHSL estate. I attended from the RHCYP/DCN new building perspective. It was the main route by which I worked within NHSL senior governance. I used the Project Director's report for the Oversight Board to provide any updates to the Executive Steering Group.

NHS Lothian Board Meetings

78. I attended NHSL's Finance and Performance committee meetings on two occasions to answer questions that were posed of me. I only attended these meetings when there were agenda items relevant to my role as SPD. More particularly, I think, agenda items would be around approval for the recommendations arising from the outcomes of commercial negotiations. Agenda items would be led by Susan Goldsmith, who as the Finance Director, was the Senior Responsible Owner (SRO) for the programme. I would be attending in support of her. I worked very closely with Susan Goldsmith. We frequently had conversations about what was happening, we were in meetings around commercial arrangements, we frequently had informal conversations about how those were going and so on. Susan was my main executive point of contact in NHS Lothian.

Strategic Liaison / Contract Review / Delivery Groups/ The Commercial Subgroup

79. The Strategic Liaison Group was chaired by Roger Thompson, IHSL. The Strategic Liaison Group was the Senior Officers Group where we came together and talked about the relationship and shared matters between NHSL and IHSL. Discussions focussed on what was happening on the ground with things like the performance of Bouygues, and the views of IHSL's on relevant matters of the project and so on.

80. I have limited recollection of the Contract Review Group and to my recollection, I did not attend it. I believe it was a group to review the payment mechanism and to resolve issues raised by Bouygues as previously described.

81. The Delivery Group would go through the action plans in some detail. I worked quite closely with the Mott MacDonald team who were gathering in the action status and evidence. Frequently they would come to me for approval to close an action once work was completed, the evidence obtained, documented and recorded. I would attend these meetings when possible.

82. The Commercial Subgroup was a subgroup of the Oversight Board. It was established at Susan Goldsmith's suggestion to provide additional focus to the commercial negotiations. It comprised members of the Oversight Board and NHSL team. I attended the Commercial Subgroup. It provided a reference group for the team involved in the detailed commercial negotiations.

Escalation and De-Escalation - Level 4

83. I was not party to the decision to escalate NHSL to Level 4 of the Performance Framework in relation to the RHCYP/DCN project. Administration of the Performance Framework is a matter for the Scottish Government. NHSL were already escalated at stage 4 for the RHCYP/DCN project when I was appointed. I understand this escalation was the reason for my appointment.

84. About a year after I was appointed, I sent an email to Fiona McQueen **(A41230028 – Email from Mary Morgan to Fiona McQueen – 7 September 2020 – Bundle 8 - Page 272)** voicing my reflections on the project and how pleased I was about its status at that time, with a view to its escalation being reviewed and de-escalated. I addressed this correspondence to Fiona as she was, as Chair of the Oversight Board, my link with the Scottish Government. It was not clear to me what the criteria were, or are, for de-escalation within the Performance Framework or if my appointment was inextricably linked to NHSL's escalation status. A lot had changed since my appointment, including the Chair and Chief Executive of NHSL. Given progress against the project and these changes, it felt the right time to raise the question of de-escalation.

85. I didn't take an interest in escalation status thereafter. It was up to NHSL and their Chairman and Chief Executive to progress. I was later made aware that de-escalation would not happen until the new hospital was fully operational.

Cabinet Secretary

86. I did not report to or communicate directly with the Cabinet Secretary or her private office. The only time I met her directly was when I accompanied her on a visit to the RHSC at Sciennes Road, Edinburgh and the DCN.

RHSC, Sciennes Road, Edinburgh and DCN, Western General Hospital Sites

87. It was not within my remit to assess whether the old sites for the RHCYP and the DCN were safe to continue operating whilst the project was being completed for the new build **(A44267042 – Letter – MW – B Houston and T Davison - NHS Lothian Level 4 Escalation dated September 2019 – Bundle 13, Volume 3 – Page 702).** From a personal point of view, they were obviously old and difficult to clean and to maintain and, from my site visits, were sub optimal for the delivery of modern healthcare. I understand that there was financial investment in both hospitals to maintain safe services pending completion of the RHCYP/DCN project.

88. The contrast between old facilities and the new RHCYP/DCN hospital was a really strong driver to get the new building completed so patients, staff and services could move into it. The new hospital had brand new equipment still wrapped in bubble wrap, awaiting commissioning in theatres.

89. I suggested that some of the IHSL project delivery team visit the old hospital sites to see the contrast. One of the Project Managers took up the opportunity and returned doubly motivated to progress completion of rectifications. It was a really big motivator to go and visit the old sites.

90. I can't comment as to the safety of these sites. I believe if they were unsafe then NHSL would have addressed those issues so that the healthcare services were delivered in as safe an environment as was possible.

Reflections

91. I have been asked by the Inquiry for my reflections from my time as SPD for the RCYP/DCN project. My principal reflections relate to the availability of infection prevention and control (and other specialist) resources for the delivery of healthcare construction projects and the difficulty that arose from the complexity of contractual arrangements between the various parties to the RHCYP/DCN project.

92. Infection Prevention and Control are very specialist resources. In my opinion, a dedicated Infection Prevention and Control specialist workforce resource should be assigned to projects of this magnitude. It is, in my view, insufficient to have workforce resources who have responsibility for inputting into the project as part of their day-to-day portfolio. I recognise, however, that Infection Prevention Control nurses and doctors are in short supply.

93. I also believe the same approach should be taken for fire safety, water safety etc. The NHS system needs to find a way of bridging the gap between clinical service and engineering requirements, technical requirements, or both. Such resourcing is not just a financial consideration. It's also a workforce planning consideration and having the skilled workforce available.

94. The creation of NHS Assure (a department of NHS NSS) addresses, to an extent, the reflections I discuss in the preceding two paragraphs. The assurance process undertaken by NHS Assure on significant healthcare projects provides health boards with a greater level of both scrutiny and support in these areas of technical skill and expertise. I say "to an extent" because the responsibility for delivery of healthcare projects still lies with health boards and it is for health boards to ensure that they put in place sufficient technical resource to deliver those projects alongside the assistance of NHS Assure. NHS Assure should not be seen as a substitute for health board level expertise.

95. I found the negotiation, drafting and agreement of SA2 to be a challenging, stressful and protracted process. Everybody involved was very professional and given the construct that was being operated within, I don't think there is anything that could have been done differently or more quickly. However, the process was complicated, and I would hope that there is a simpler way to manage contracts and contracting in future cases.

96. I have been asked if my role was pivotal in the turnaround of the project. I think my role, whether it was me or somebody else, brought a degree of assurance, and maybe it's for other people to decide if it added value, but I don't believe we would have got through all those supplemental agreement negotiations as quickly unless I had taken some of the interventions I did.

97. In terms of eventual outcome, the result would always have been the same regardless of my involvement. The hospital would have opened, and patients and services would be using it. It's the timeline that maybe would have changed in that space. Everyone had a role to play in getting the hospital opened. My role was to challenge the status quo that had existed prior to my appointment. The ask of me had been to conclude the works and have the hospital fit for occupation within a certain timeframe. This timeframe changed because there were different issues that presented but the facility was fit to occupy and subsequently opened against deadline and is functioning today.

98. I think it is for other people to decide if I brought any added value. I probably brought added assurance and, publicly, was somebody appointed to solve the problem. I think I did specifically bring to it clinical knowledge, from my nursing background, so I did understand the clinical service needs and patient flow and pathway in a practical sense. I understood the NPD model and how difficult that could be to execute, having been through that experience in one of the first projects that was opened. I knew a lot of the people involved within NHSL, NHS NSS and Scottish Government so could build on existing relationships. The IHSL team and legal teams got to know me. From that perspective, I had the ability to influence, and I think I had credibility over and above others who may have been appointed to the SPD role.

Declaration

99. 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.