Scottish Hospitals Inquiry

Witness Statement of

Jeane Freeman

Witness Details

1. I am Jeane Tennent Freeman OBE. I am the former Cabinet Secretary for Health and Sport.

2. In this statement I address the following:

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    2.3. Role of Cabinet Secretary in The Royal Hospital for Children and Young Persons / Department of Clinical Neurosciences project (RHCYP/DCN)
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Professional Qualifications and Background

3. When I left school, I trained and worked as a nurse. After I left nursing, I attended the Glasgow College of Technology (which later became part of Glasgow Caledonian University) from 1975 to 1979, initially studying for a Personnel Management Diploma then an honours degree in sociology and politics. In 1979, I became chair of the National Union of Students, Scotland. I then worked for the British Youth Council and became its General Secretary. I then worked with Saatchi and Saatchi's charities unit and I was also a researcher in the House of Commons and a bookkeeper for Student Travel.

4. I then moved back to Scotland to undertake a feasibility study for Apex, which is an employment focused organisation that works with people who have a criminal record. I established Apex Scotland in 1987 and was their Chief Executive for 13 years until 2000. I was awarded an OBE in 1996 for services in relation to the rehabilitation of offenders.

5. I joined the Civil Service as a Senior Civil Servant in 2000. I worked in Education initially to Sam Galbraith then Jack McConnell. I then left that role to work as a Senior Special Adviser to Jack McConnell when he was the First Minister. Between 2001 and 2005, in this role, I worked on the Scottish Budget, the government's legislative programme, relations with the UK government and in the Finance, Health and Justice portfolios.

6. In 2005 I set up my own Consultancy business. I was appointed as a member of the Parole Board for Scotland in 2006. I also served on the Scottish Police Services Authority Board from 2013 to 2015. In 2008 I was appointed to the board of the National Waiting Times Centre, the special health board that runs the Golden Jubilee Foundation which includes the Golden Jubilee National Hospital. In 2011 I was appointed as Chair to that Board, stepping down from this role in March 2016 in order to stand as an MSP candidate for the Scottish Parliament in May 2016. As a Board Member my role was to provide constructive scrutiny and challenge to the work performance and proposals of the Executive Directors including the Chief Executive Officer (CEO) and to

contribute to the specific work of the Board committee, including clinical governance, staff governance and audit. As Board Chair, my role was to lead the Board in its work of constructive scrutiny and challenge, support for Executive Directors and to lead the strategic direction of the Board as it contributed to delivering safe, effective, and person-centred care to the NHS. As a Board member and then as Board Chair, I learned a great deal about clinical and patient care advances, relationships between NHS Boards across Scotland, funding processes and challenges and the critical importance of effective clinical and strategic leadership to the provision of safe and effective care. I was appointed as a Lay Member to the Judicial Appointments Board for Scotland, commencing November 2011 for a four-year period.

7. In 2016 I was elected to the Scottish Parliament representing the constituency of Carrick, Cumnock, and Doon Valley. I was appointed as Minister for Social Security which I held from 2016 until 2018, when I became the Cabinet Secretary for Health. I held this post until 2021.

8. I am currently Dean for Strategic Community Engagement and Economic Development at the University of Glasgow. In this part-time role, I look at all of the University's strategic projects through the lens of turning their research outputs into deliverables. It is helping with their overall intent as a university to be a civic university contributing to deliverable economic development and effective community engagement. Our current work focuses on health innovation, precision medicine and data validation projects in the Glasgow Riverside Innovation District, which covers the Govan and Partick areas of the city on both sides of the river.

Role as Cabinet Secretary for Health and Sport

9. I was appointed Cabinet Secretary for Health and Sport on 26 June 2018. My role and responsibilities as Cabinet Secretary were, first of all, to ensure the delivery of the health and sport commitments in the Government's Programme for Government, including manifesto commitments, to contribute to the wider

Programme for Government, to ensure the safe and effective delivery of Health and Social Care in Scotland. These health and social care elements of the programme are delivered through health boards and local authorities. As Cabinet Secretary, it was my job to provide overall strategic leadership to Boards, support Boards to deliver their responsibilities as best I could and, through the Ministerial appointment process and subsequent engagement for non-executive board members and Board Chairs, hold Health Boards to account for their work. In Scotland, our NHS is a single entity and, whilst comprised of different elements and funding mechanisms, does not operate with individual Trusts or internal competition (as is the case in England) and the relationship between the Health Secretary and Health Boards is a direct relationship, not mitigated by or conducted through any other agency. As Health Secretary I, as with other Government Ministers reported to and was scrutinized in the conduct of my responsibilities by the Scottish Parliament.

10. I worked hard to stay on top of my Ministerial brief. While there was nothing that came to me that I did not read, I did prioritise the order in which I worked through issues given that some, inevitably, are more urgent than others. I always had a box of papers, and I would sort out on the way home what I still needed to read and make decisions on and would tell my private office about it that night. I would deal with matters that could wait until the morning on the car journey to work the following morning, because during the day you do not have a lot of time to read everything, especially when Parliament is operating because, to an extent, Parliament dictates your schedule. I had a really good private office, who ensured that I was provided with all of the information I needed to perform my role, but my approach was to read everything myself. I worked for a First Minister who read everything, and I did not ever want to be in a position where she had read or was aware of something about my job that I had not read or was unaware of.

11. The private office operated as a single unit that covered the junior health ministers as well as me. It was deliberately, and quite rightly, constructed like that by Andy Corr, my principal Private Secretary. There were five staff members, one of whom would be with me in all meetings taking notes and

would then, at the end of a meeting, check with me whether I wanted them to follow anything up. If I had phone calls, which I did on occasion make or receive on the way to or from home, I would then tell Andy Corr so that he would know and have a record of whether I had agreed anything or required action to be taken.

12. It was important for me throughout my time in office to understand what statutory responsibilities and powers I had in respect of my remit.

13. The National Health Service (Scotland) Act 1978 states, at section 1, under the heading “General duty of Secretary of State”, that “(1) It shall continue to be the duty of the Secretary of State to promote in Scotland a comprehensive and integrated health service designed to secure — (a) improvement in the physical and mental health of the people of Scotland, and, (b) the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services in accordance with the provisions of this Act.”

14. Section 2 of that Act states “(1) It is the duty of the Scottish Ministers to promote the improvement of the physical and mental health of the people of Scotland. (2) The Scottish Ministers may do anything which they consider is likely to assist in discharging that duty including, in particular— (a) giving financial assistance to any person, (b) entering into arrangements or agreements with any person, and (c) co-operating with, or facilitating or co-ordinating the activities of, any person.”

15. Section 2(2) of that Act gives the Scottish Ministers very wide powers, and I was satisfied that it was open to me, as the Cabinet Secretary holding the health portfolio, to apply those powers in a proportionate way. By that I mean adopting a ‘light touch’ if I had assurances from those advising me that the health boards were dealing with matters well; and increasing my level of direct scrutiny and intervention if that became necessary in light of it being reported to me that a health board was performing less well or if failures came to light.

16. As Cabinet Secretary, I was supported by clinical advisors from the Chief Medical Officer and the Chief Nursing Officer's Directorates; Office of the Chief Pharmacist; Chief Dental Officer; Chief Scientist (Health); Health Protection Scotland and Health Facilities Scotland; the Director General (DG) for Health and Social Care and his or her team of directors; and people who could explain how infrastructure projects are built, such as the Scottish Futures Trust.

17. The role of DG for Health and Social Care within the Scottish Government incorporates the role of Chief Executive of the NHS. The DG is the accountable officer for the whole of the NHS. When I was first appointed Cabinet Secretary, Paul Gray held this role. He was succeeded by Malcolm Wright on an interim appointment basis on 11 February 2019 and then as a permanent appointment from 17 June 2019 until his retirement in July 2020. DGs report to the Permanent Secretary.

18. The DG is a principal policy advisor to the Cabinet Secretary, so the DGs worked closely with me to understand what my goals were and to make sure that the civil service provided what I needed to achieve them. This included forming a strong team of Directors within the Directorate, upon whom I could rely with confidence. When Malcolm Wright came into post, he ensured that the team was robust and I, in turn, had confidence in them.

19. As I mentioned, the DG is also the Chief Executive of the NHS. To fulfil that part of the role, the DG would be meeting with all of the Board Chief Executives regularly, both formally and informally. They were the accountable officers within their health boards, which are each separate statutory organisations.

20. I worked closely with the DG and the Directors within the Scottish Government Health and Social Directorate; and also met regularly with the individual health board Chairs (who are appointed by the Scottish Ministers) and with the Chairs collectively.

21. The Directors I worked with at the time included, Catherine Calderwood (Chief Medical Officer)(CMO) and later Gregor Smith; Fiona McQueen (Chief Nursing Officer)(CNO); Shirley Rogers (Director of Health Workforce); and Christine

McLaughlin (Director of Finance and Infrastructure). There was also Richard Foggo (Director of Population Health), who was responsible for the whole of public health and improvement and the setting up of Public Health Scotland; Eleanor Mitchell (Director of Health and Social Care Integration); Donna Bell (Director of Mental Health); and John Connaghan (Chief Performance Officer). I dealt with all of these directors directly.

22. I met with the whole Health and Social Care Directorate team on a weekly basis, immediately following the Cabinet meeting. This allowed us to have an hour every week, during which I would give relevant feedback from the Cabinet meeting and then we would discuss the live issues being handled by the team, so that I could hear directly from the directors on the issues at hand.

23. As Cabinet Secretary, the starting point in relation to any NHS project was for me to be assured, at the highest-level, that projects being run by the health boards were progressing on time and within budget. It is not the role of a Cabinet Secretary, generally speaking, to be involved in the day-to-day progress and decision-making on any project commissioned and being managed by a local health board.

24. At the time of the Royal Hospital for Children and Young People/Department of Clinical Neurosciences (RHCYP/DCN) project it was the responsibility of the local health board, in the first instance, to manage the project. That remains the current position, so far as I am aware. If there were any disputes between contractors and a health board, it was for the health board to resolve those, albeit if there was requirement for additional funds, then it was the Scottish Government's job to see if and how, those funds could be provided. Health Boards were expected to keep Scottish Government officials apprised of any area of difficulty or dispute that carried risk to completion timescales or budget.

25. The Scottish Government has to have a reasonable degree of trust in each NHS Board. If you asked a health board that managed a large budget, had an experienced Chief Executive, a director of estates and a medical director whether they had carried out what they were supposed to and they confirmed

that they did, it is reasonable for the Scottish Government health directorate to rely upon assurances given.

26. I do not believe, however, that health boards are autonomous units. They are the delivery arm of our NHS. They have an important role in contributing to the strategic direction and resource requirements of health delivery in Scotland, a responsibility to apply the agreed strategy to their local circumstances of which they should be fully aware and an accountability in respect of standards and performance. I do not believe that they have, in some instances, the degree of discretion and autonomy that they might believe they have. That undoubtedly led to a number of difficult conversations between me and some health boards. One example I would cite is the situation in NHS Highland, which had prompted a group of whistleblowers to make public their claims of bullying and intimidatory behaviour by key senior staff and allegations as to the failure of the board to act effectively, or at all, in response to their grievances and complaints. Officials from the Scottish Government Health Directorate, including the then DG/ NHS CEO had provided support and counsel over a lengthy period, but NHS Highland had not responded sufficiently to that, and the behaviours continued. It was at that point I intervened, commissioned an independent review by John Sturrock KC and took decisions to implement recommendations flowing from his review. That involved a number of difficult conversations with the Chair and members of the NHS Highland Board. I remain of the view that our NHS health boards are the delivery arm of the NHS, with less discretion to determine their overall direction and behaviours than some Boards may believe; and I would repeat those difficult conversations if I were still in post and had the requirement to do so.

Period between September 2018 and 1 July 2019

27. When I was first appointed as Cabinet Secretary, I received regular high-level briefings on the progress of key elements of the various health board building projects, including RHCYP/DCN.

28. In relation to the RHCYP/DCN project, by way of background to the project, I understood that in March 2014, the NHS Lothian Board (NHSL) appointed Integrated Health Services Lothian Limited (IHSL) as its preferred bidder. IHSL's team comprised Macquarie Capital, along with IHSL's subcontractors: Brookfield Multiplex (Multiplex), Bouygues Energies and Services (Bouygues) and HCP Management Services Limited (HCP) (who collectively are often referred to as "Project Co"). As the project was NHSL's, oversight and day to day management of the project sat with NHSL. The Scottish Government's health finance team were kept abreast of progress on the project and officials within that team can provide the Inquiry with detail in that respect. The Scottish Government's principal interest was in the financial, rather than technical, aspects of the project.

29. There had been a dispute between NHSL and IHSL, their contractor - the full details which I cannot (with the distance of time) recall. Around September 2018 I was issued a briefing from the Scottish Government's Health Finance Directorate and asked to note the risks around the project. I was aware that it was Multiplex who were the main contractor for RHCYP/DCN and of all the issues that were associated with them and the Queen Elizabeth University Hospital (QEUH). I thought, we can't change contractors without an exceptionally good reason so I had to go on the basis that NHSL were aware, were asking for assurances and were on top of the situation, not least because all Board CEOs had been kept up-to-date with the ventilation and water issues arising at QUEH and assurances had been sought from all that they were taking proper account of these matters in the expected regular inspections and maintenance of their own estate and in any new builds underway or in design.

30. Although I had no direct involvement in negotiating the Settlement/Supplemental Agreement (SA1), I would have been briefed on the resolution of the dispute between NHSL and IHSL as regards the Scottish Government signing off on the provision of any additional funding, because that was about money that had to come from somewhere else within the healthcare budget. SA1 **(A32469163 - Settlement Agreement and Supplemental Agreement relating to the Project Arrangement for the provision of RHSC**

and DCN between Lothian HB and IHS Lothian Ltd – dated 22 February 2019 – Bundle 4 – Page 11) between NHSL and IHSL was dated 22 February 2019. Others will be better placed than me to speak to the detail of this dispute and the terms of SA1, but the outcome was that the project was back on track and the RHCYP/DCN was expected to open on 9 July 2019. I was not aware that SA1 involved compromises to the ventilation system and deviation from normal guidance. Given that my officials were looking at this from a finance perspective, were not technical experts and no derogation from the normal guidance had been sought or highlighted to them, I would not expect them to have picked this up. SA1 could be seen as a missed opportunity for NHSL to have identified some of the reduced ventilation standards in the build prior to the critical issue coming to light.

31. I was not aware of any other issues with the RHCYP/DCN project thereafter (until July 2019) and was told that the project was progressing and that they would make their planned move date of 9 July 2019.

32. I met with the chairs of the NHS boards on a regular basis, possibly every four to six weeks. This gave me the opportunity to talk to them about their own board and whatever was current. One of these meetings was on 24 June 2019, when I met with Brian Houston who was the Chair of NHSL. It was a couple of weeks before the planned migration date of 9 July 2019. I can't recall everything we talked about, but we would have touched on how things were progressing for the new hospital, and he did not raise any concerns or issues. We did not have any formal minutes taken at these discussions, but either my principal private secretary or the deputy would have been with me; and they would have taken a detailed note and, if there was any follow-up action required from my side, then they would send the email commissioning that follow-up action.

33. I was not aware of any communication from Scottish Futures Trust (SFT) regarding any possible concerns around the planned migration date set for 9 July 2019. The SFT are infrastructure specialists, employing a mixture of technical, legal, and financial specialists, who work hand in hand with the public and private sectors to maximise the benefits coming from their infrastructure

projects. That includes looking at how projects are paid for, how they are built, how they are used or how they are maintained. They largely exist to ensure that major capital projects are properly financed, procured, and delivered into the public sector.

Ventilation issues on the radar

34. In January 2019 we had what has been referred to by some as the "Pigeon Incident" (the reporting of deaths where potential infection caused by pigeon droppings was a 'contributing factor') at the QEUH. Once I became aware of the very concerning issues at QEUH, I wanted a greater level of assurance that the issues arising were being given particular attention by the Chief Executives in all of our territorial boards, particularly those with ongoing infrastructure projects of all sizes, and that standards were being complied with. I instructed Paul Gray, as the Director General of Health and Social Care, to write to all NHS Boards to that effect, which he did. A letter was sent out by Paul Gray to all the Chief Executives of the Health Boards in Scotland **(A35270542 - Letter from DG Health & Social Care and CE NHSS Scotland setting out a set of actions about an ongoing incident (Cryptococcus infections in QEUH) – 25 January 2019 – Bundle 4 – Page 8)**. It included a section relating to assurances being sought that all critical ventilation systems were being inspected and maintained in line with SHTM 03-01. This was to make sure that any maintenance issues were being followed through and that they were maintaining an adequate maintenance programme. The focus was on maintenance of existing estate because, at least in part, the issues arising at QEUH appeared to have been exacerbated or contributed to by inadequate maintenance performance.

35. I expected that each health board would provide detailed responses, setting out what they were doing to address all points in the letter, what they had found and how recently any action might have been taken.

36. The responses were all coordinated by Health Facilities Scotland (HFS). Gordon James was responsible for this at HFS, on behalf of the Scottish

Government. HFS have the technical expertise to understand what was coming back and be satisfied (or not) with the responses received. I expected that the responses would be reviewed and HFS would confirm that the position of each health board either satisfied them or that they would pursue matters further where they thought that a check was done too long ago and instruct that they should be conducted more regularly.

37. Whilst at this distance in time I cannot recall the detail of the update I would have received as it related to each Board, I would have received a précis of the responses, including any actions Boards had undertaken or were scheduled to undertake, together with my officials' advice on whether these were satisfactory.

38. On 27 June 2019, Michelle Ballantyne MSP asked me a question in Parliament about whether I had received assurance that the same issues experienced at the QEUH would not be experienced at the new hospital. Based on briefing from my officials, on the basis of the knowledge they had from NHSL at that time, my reply to that question was that we had that assurance, and that "NHS Lothian did not take ownership of the site unless it was absolutely assured that those steps had been taken" **(A41232683 - Email chain regarding Michelle Ballantyne MSP Parliamentary Question – dated 9 July 2019 – Bundle 13 – Volume 3 - Page 40)**. In hindsight I think the assurance process undertaken by HFS as described above was sufficient because I think it is entirely the health board's responsibility to meet all required standards and to alert the Scottish Government should there be any concerns. The people on these boards have really responsible jobs, for which they are paid well, and I expect them to do their job. This view may, from time to time, have created some tension between me and the health boards. A few months after the critical care issue at RHCYP/DCN (which I discuss below) came to light, I requested details of all communication that had taken place with NHSL, seeking assurances and their respective responses. This came as a result of information that HFS were struggling with resources. One of the communications detailed,

"While NHS Lothian confirmed that the engineering systems were in compliance, HFS thought there were a lot of assertions and were looking to gather more evidence to support the position that NHS Lothian were reporting. However, the issues at QUEH earlier this year became the focus of HFS during the first half of the year, so that evidence gathering had not progressed as quickly as we would want given the current position" **(A41231046 - Email from Calum Henderson to Cabinet Secretary for Health and Sport responses to request regarding Ventilation– dated 23 September 2019 – Bundle 5 - Page 5)**.

It may have been the case that if the information provided by NHSL had been reviewed earlier then the critical care issue could have been discovered sooner.

Events of 2 July 2019

39. On 2 July 2019 I was told by the then Director General for Health and Social Care, Malcolm Wright, that there was an issue with the ventilation in the critical care department of the RHYCP/DCN (thereafter referred to by some as "the Critical Care Issue"). This had been brought to his attention in a call he had received that day from the Chief Executive of NHSL. The standards required ten air changes per hour, but the system was only delivering four air changes per hour. A number of questions immediately came to mind, including "What does that mean? Why are we only finding out about this now? What are we doing about it?" Four air changes per hour was not even 50% of what was needed.

40. It was reported to me that there was a suggestion from NHSL that they could migrate some of the departments from the existing hospital to the new building on 9 July 2019 as planned. My initial reaction was one of serious concern. I doubted whether this was a credible proposal because no clinician will guarantee that even a standard procedure carried out daily, even as an inpatient, will never result in something happening where the patient requires critical care. So, I couldn't immediately see how it would be possible to safely migrate patients, because they might need to access critical care facilities. In addition, we weren't clear at that point what would be required to fix this. I also

did not want a repeat of the QEUH, where you try to retrofit to fix something and that potentially raises other issues around infection control.

41. Putting to one side the fact that I was furious about this situation, not least because this was the first that I was hearing of it, I do not believe there was any point at which I thought there was a safe and credible option other than not migrating patients over to the new hospital on 9 July 2019.

42. A briefing note was prepared by NHSL and forwarded to the Scottish Government on 2 July 2019 (**A41020525 – Email from Alan Morrison to Cabinet Secretary for Health and Sport attaching a briefing on emerging issues from NHS Lothian – dated 2 July 2019 – Bundle 7 – Volume 1 - Page 38**). It advised that NHSL had been informed the previous evening by the commissioning engineers, IOM, that four four-bedded rooms and five single rooms in the critical care unit had been discovered to achieve only four air changes per hour, when the applicable guidance required ten air changes per hour. It also noted that IOM had found non-compliance issues within the new hospital's theatre environments.

43. At the foot of the first page of this briefing note, NHSL states that "it should be noted that there is zero rate of air change in critical care at the existing Royal Hospital for Sick Children (Sciennes). There are 19 critical care beds at Sciennes. The new RHCYP has 24 beds." I read this as NHSL saying that although the new hospital did not meet the required standard, they thought it was better than the existing facilities at Sciennes. The existing DCN facilities were, arguably, in a worse condition than Sciennes. I took this into account as part of the balance in my decision-making. Whilst no specific problem had been identified at this point with the facilities the DCN would use, patients here might also require both theatre-based treatment and/or critical care, so I was concerned that the sub-standard issues now identified could also impact upon the DCN and that would require further consideration.

44. After I had received this news on 2 July 2019, many meetings and telephone calls took place between 2 and 4 July 2019. I had various questions that I needed to have answered. At this point I was considering what needed to

happen and I knew I had to make a decision quickly, but I needed more information. There was advertising and a huge amount of other activity ongoing in relation to the intended migration date of 9 July 2019. It would not have been enough just to say that the migration was not going to take place on the planned date. Patients, staff, and the general public would need to know what was to happen with scheduled appointments, where to take patients in need of emergency care; when migration would take place and what was being done about all of the arrangements. I needed to be able to answer these sorts of questions because (a) that's just reasonable and fair; and (b) people want some assurance. This was a big bolt from the blue; it was going to be unsettling and destabilising; and both patients and staff would need to feel confident that somebody had taken a grip of the situation and that it was going to be fixed. I certainly couldn't answer all questions at that initial point, but there were some key questions I knew I would need to be able to answer to patients, staff, the wider public and the Scottish Parliament and, at that stage, could not.

45. The other element in my decision making was: if this had come to light barely a week before the intended move date and everything up until then had been assured to be 'on track', was everything else constructed properly? Now that this had happened, how could I be sure that the drainage, the gases, and everything else about this building was as it should be? The simple fact was that I couldn't be that sure and, in that moment, I felt that I had lost trust and confidence in the assurances that had been given about the readiness of the RHCYP/DCN to open and deliver safely to patients.

46. In the briefing from NHSL **(A41020525 – Email from Alan Morrison to Cabinet Secretary for Health and Sport attaching a briefing on emerging issues from NHS Lothian – dated 2 July 2019 – Bundle 7 – Volume 1 - Page 38)** there was also mention that they were making enquiries with a view to making a decision as to whether the services would be migrating or not. Because of the seriousness of the situation and because this hospital was to be a Centre of Excellence that would provide services and expertise to patients from a wider geographical location than just the Lothians, I was very clear that this decision would be the decision of the Scottish Government, not one for

NHSL. I think NHSL thought this was their decision to make. However, the very fact of NHSL having reported the situation to Malcolm Wright, is indicative of NHSL realising that this was not a matter they would (or should) be left to deal with alone.

47. For me to make the right decisions as to what needed to happen, for all directly impacted and in order to responsibly report to the Scottish Parliament, I needed to take the advice of my principal advisers.

48. The first written briefing I received was from Alan Morrison in Health Finance, who sent me an email at 1653 hours **(A41020525 – Email from Alan Morrison to Cabinet Secretary for Health and Sport attaching a briefing on an emerging issues from NHS Lothian – dated 2 July 2019 – Bundle 7 – Volume 1 – Page 37)**. This email provided a note of the issue with the air change rates in the paediatric Critical Care Unit and gave the background, outlined the derogation and NHSL's assessment of the situation at that time.

49. From this point, given the urgency of the situation, I was having multiple conversations and receiving many 'real-time' updates from all of my advisers. I needed advice on the balance between the facilities staying where they were in Sciennes and existing DCN (which was arguably in more urgent need of the move that the Sciennes facilities) and moving to the new facilities. I needed views about staffing and to think through some of the practicalities.

50. I was being advised by the DG and all of the relevant Directors. The CMO and CNO were both on leave when the Critical Care Issue came to light on 2 July 2019, so their deputies stepped in to provide me with the advice I needed from both of those Directorates.

51. There were two categories of questions we needed to ask. One related to all the things we needed to know in order to put everything that would be required in place in the run up to making the announcement. That included everything from how to tell people (staff, patients, unions, the general public, the First Minister, and Parliament – which had just gone into recess), to re-arranging staff rotas and appointments. Then, running parallel to that, we needed to

understand how this had happened; how could we be assured about the other areas; and what level of work would be needed and how much would that cost? Was the issue contained to the ventilation in critical care - was the ventilation everywhere else, okay? Were the water, drainage, and gases all right? We needed to quickly interrogate what had to be done in order to understand the full scale of the problem that required to be resolved, what would be required in order to resolve the problem and how much it was going to cost.

52. We were aware that in the background there were the issues with the QEUH, but primarily it was about patient safety and what would be safe for the RHCYP/DCN. Moving people to the new site did not immediately appear to be a safe option.

53. If it were true that some individuals within NHSL were aware of the issues within the critical care department, as early as the 24 June 2019 **(A41020535 - Email from Christine McLaughlin to DG Health & Social Care et al about water and ventilation issues, includes two email attachments on critical care ventilation timelines – dated 10 July 2019 – Bundle 7 – Volume 1 – Page 275),** then I would have expected that this should have been escalated that same day and without any delay to someone within the Scottish Government.

Events of 3 July 2019

54. I attended a meeting with Malcolm Wright (DG), on 3 July 2019 and he told me that he had received an email from Tim Davison (Chief Executive of NHSL), setting out potential options for proceeding **(A41020529 – Email from Malcolm Wright to DG Health Social Care on commissioning and ventilation issues at RHCYP/DCN - dated 3 July 2019 – Bundle 7 – Volume 1 – Page 66)**. He indicated that his preferred option was re-phasing the move over the following weeks and months, starting with allowing the DCN to move as planned on 9 July 2019. I viewed this as NHSL offering their views about what they thought should happen. I suspect that they believed they were offering their decision about what should happen, but I did not believe it was their decision to make.

55. I took the view that I could not leave this decision in the hands of NHSL because they had not been aware of the problem until the last minute. Instructing IOM is standard and so was not an indicator at all that they were on top of the situation. In addition, given the criticality of ventilation, which was not identified to be sub-standard until mere days before 'go live,' I could not have confidence in the governance performance of NHSL and consequently that all other required standards in the build had been met.

56. I am referred to (**A41020529 - Email from Malcolm Wright to DG Health Social Care on commissioning and ventilation issues at RHCYP/DCN - dated 3 July 2019 – Bundle 7 – Volume 1 – Page 66**), which refers to a meeting attended by John Connaghan, the then Chief Performance Officer, NHS Scotland. There is reference that various matters had been agreed, one of them being the clinical risk assessing and planning of the re-phased moves in line with option 4 (re-phase the timing of the move into the building to allow a phased occupation over the next few weeks and months). John would have been at that meeting observing from a Scottish Government perspective. He may well have made it clear that it was not for NHSL to determine this. I don't take the "we agreed" as implying that he agreed at all **(A41020529 - Email from Malcolm Wright to DG Health Social Care on commissioning and ventilation issues at RHCYP/DCN - dated 3 July 2019 - Bundle 7 – Volume 1 – page 68).**

57. I knew that the preference for NHSL was for some kind of phased move, commencing 9 July 2019. I knew that I did not agree with that.

58. I was aware that John Connaghan telephoned the Health Board later that day and advised them that any planned communication for the following morning should not go ahead. Given that my final decision on how matters were to be dealt with had not yet been made, it was entirely right for John to say to NHSL that they should not be putting out any communication and that the Scottish Government would now be making all the decisions about what happens here and would have a number of questions and requirements of NHSL.

59. From my point of view, I was really clear from the afternoon of 2 July 2019 that I was making the decision, and I am confident that that was communicated to NHSL by my officials. NHSL may have chosen not to pay attention to that and to proceed on the basis that they would decide how it was going to be resolved; and Scottish Government would be informed and given a role in a communications plan. All of that seemed, to me, to spectacularly miss the point. I think it's probably fair to say that my level of concern at this situation grew over the days. You can't talk about putting patient safety first and then say you want to have a phased entry from the date originally planned without having supporting information to confirm that it will be safe in all hospital areas including theatres and that all required clinical and safety standards had been met to confidently allow patients and staff to enter and use the building. We did not have that level of confirmation and assurance because NHSL could not provide it; and any attempt to move patients and staff into some areas of the new hospital and then 'retrofit' the sub-standard areas carried clinical risk (for example, from airborne dust). And of course, at this point, we could not be sure the extent of any 'retrofit' required.

Events of 4 July 2019

60. On 4th July 2019, Malcolm Wright sent a letter to the NHSL saying that the decision to delay the move in its entirety had been made **(A35827763 - Letter from Malcolm Wright to Tim Davison confirming that Cabinet Secretary has taken the decision – dated 4 July 2019 – Bundle 7 - Volume 1 – Page 79)**. That letter set out details regarding "further information that has emerged over the course of yesterday and last night." This was about the fact that we still didn't know why it took until 2 July 2019 before anybody knew there was a problem. We didn't know if everything else was okay with the build, and we didn't know what NHSL thought should happen.

61. By now I also had the view of the Chief Medical Officer and Diane Murray as the Deputy Chief Nursing Officer, along with Malcolm Wright's views as the Director General from all of the ongoing discussions since 2 July 2019.

62. I held a meeting with all the health and social care directors. This allowed me to hear their views from their respective areas of responsibility. It was to make sure they all knew what we knew and allowed me to hear what each of them thought should now be our collective view on the way forward, that is, what we should do as a government. I wanted to know if anyone disagreed, and I wanted to know why because I was about to enact a really critical decision with lots of consequences. It was important that I knew what everyone thought.

63. I had already had numerous conversations with Malcolm Wright, John Connaghan, Dr Calderwood, and Diane Murray, and I had been keeping the First Minister briefed. I was also receiving updates from Alan Morrison (Deputy Director in Health Finance), who understands and has responsibility for projects like this (because whatever happened, this was going to cost money, there was no question about that). He was a key connector. I also had input from Shirley Rogers, who was in charge of people. I also had the communications team with their particular advice about how the various strands of communications might be handled. They all attended this meeting collectively to assist me in making the decision regarding how to proceed.

64. In holding this meeting, I was looking for that assistance, information that would give me consequences I might not have thought of and challenge: the “Well that’s all very well Cabinet Secretary, but have you thought about…” question, because once you understand consequences you then can consider whether you can mitigate those consequences. You have to decide whether any potential consequences outweigh what you think you need to do.

65. I was looking for views, not to substantiate what I had decided, but that would deepen my understanding about the consequences of my decision-making.

66. I think it is fair to say that Malcolm Wright was supportive of the decision made. John Connaghan was supportive but worried about the consequences. My recollection is that the Chief Medical Officer was pretty clear in her view that the opening should not go ahead on 9 July 2019 as planned and specifically wanted to have the opportunity to discuss with clinical colleagues in the DCN

what might be needed for them and their patients. Finance were worried about money, as finance should be and, for the others present, it was more about thinking about what we needed to do once the decision had been made.

67. The Deputy Chief Nursing Officer discussed the staff involved, who would all need to be written to and told where they were supposed to go on 9 July 2019 and thinking about the outpatient and inpatient appointments that would have to be rearranged.

68. Part of that discussion was just getting a long list of everything that needed to be covered off but, also consequences like, if patients and staff are staying where they currently are, what would we need to do to ensure that those current facilities were as safe as they could be (for, at this point, an unknown period).

69. The principal risk considered was that if it was not currently safe to move patients into the new facility, how safe would it be to keep them where they were, and what could we do to make that safer.

70. We needed to keep staff on board, not least because everyone was super-excited about moving to this new facility. Why wouldn't they be - it looked fantastic. The new rotas had been set up, packing up had been done and holidays arranged. I was about to tell them all they could not move when planned and I couldn't say when the move would actually take place. I was very aware that morale would likely dip considerably. People would be deeply disappointed, so we needed to give them assurance that we understood and were taking the situation very seriously. This was not least because, to a degree, sensibly, NHSL had slowed down any investment in Sciennes or the existing DCN. That needed to be addressed. There was an incredibly long list of things that needed to be done, all of which needed to be worked through and prioritised.

71. As part of ongoing talks and meetings, my Directors (Alan Morrison and possibly others) were working closely with Health Facilities Scotland / Health

Protection Scotland (HFS/HPS) and considering advice they could give. I would then know that we could commission them to do work and look at assurances they could obtain and give to the Scottish Government. Obtaining advice from HFS/HPS was a parallel exercise running with everything else that was going on.

72. Everyone in attendance at the meeting I held with the Director General and my other senior Scottish Government officials on 4 July 2019 was in agreement that no services should be migrated on 9 July 2019. Although all of my Directors in attendance were in agreement, some were more worried about the consequences than others. Brief notes of the meetings and importantly of all actions agreed would have been taken by my principal private secretary, Andrew Corr. The decision taken and outputs from the discussion were reflected in the letter that the Director General issued to NHSL that day **(A35827763 - Letter from Malcolm Wright to Tim Davison confirming that Cabinet Secretary has taken the decision - dated 4 July 2019 – Bundle 7 – Volume 1 – Page 79)**.

73. The impact upon patients and their family members of a delay in moving services to the RHCYP/DCN and remaining at the sites in Sciennes/ Western General Hospital (WGH) was high in my mind. I was thoroughly briefed on the conditions at the sites, including the advanced stages of preparations to vacate these sites and consequent reduction in all but critical maintenance of these sites pending the move to the new facilities. I was aware that the conditions at the existing sites were far from ideal (hence them being replaced by the RHCYP/DCN). I was also aware that, despite those facilities being far from ideal, they were providing a safe environment for patients – something that on available information between 2 July 2019 and 4 July 2019 I had no assurance of in relation to the RHCYP/DCN.

74. The timescales concerned did not allow for a detailed risk analysis exercise, comparing and contrasting the pros and cons of remaining beyond 9 July 2019 at Sciennes/ WGH or moving on 9 July 2019 to RHCYP/DCN. There was no time to record a detailed risk assessment. As such, I had to make my decision

based on all available advice from my advisers (including clinical advice from the offices of the Chief Medical Officer and Chief Nursing Officer, together with advice from HFS/HPS) and that decision, essentially, paused the move to allow time for more detailed consideration of all of these issues.

75. I didn't believe that NHSL would accept that my decision was correct. I decided that all communication both internal and external would need to be signed off by the Scottish Government. This was based on my view, and particular experience with the Greater Glasgow and Clyde Health Board, that our boards did not always communicate well or clearly with patients and the general public in times of crisis. The risk around communications was heightened if NHSL disagreed with the approach being taken. I was very aware of the importance of communications being transparent and delivered using straightforward language. I also understood, from previous experience, the importance of owning up to what you don't know. I think all of these are key elements of good communication. I wanted to be sure that all internal and external communications were written in a way that conveyed an understanding of how it might feel to be reading this difficult message; provide assurance where that could be given; and state with honesty where assurance couldn't be given but give a commitment as to what would be done next.

76. I also discussed matters with the First Minister in order that she knew what was going on and what I intended to do. Her critical question to me was whether I was sure the correct approach was being taken. I confirmed that I was sure that the approach was correct, and I am grateful for her support in confirming she was content with that. We issued a briefing to the First Minister that day, which explained everything to her, set out what I was doing and how I would keep her informed **(A41444207 - Briefing for First Minister on RHCYP – dated 4 July 2019 – Bundle 13 – Volume 3 – Page 89)**. She supported my decision and didn't have any other involvement or make decisions regarding the project beyond being regularly briefed on progress. If the First Minister had not agreed, I am sure she would have intervened.

77. A lot of other activity was also ongoing. I wrote to staff; spoke to the unions (and thereafter maintained a continuous dialogue with the unions); wrote to MSPs in order to explain what I had done and why I had done it (N.B. the Scottish Parliament was in recess at the beginning of July 2019).

78. We set up the telephone line so that patients, relatives, and members of the public could phone in and find out about their appointments and whatever else they needed to know on a practical level about what was happening - the kind of things that staff go to straight away.

79. The Scottish Government were dealing with the situation on an emergency incident management basis. I was clear that patient safety and staff welfare had to be at the heart of decisions being made. I instructed my officials to work at pace in conjunction with NHS National Services Scotland (NHS NSS), drawing upon the technical expertise of HFS/HPS to determine what needed to happen in order to get the new facilities open as soon as it was safe to do so. At that early stage it was hoped that the delay might only be one of a matter of weeks, but further information was required as a matter of urgency in order to understand whether that would in fact be the case.

80. It was clear that significant work would require to take place in order to examine how this had happened, what required to be done to rectify the immediate problems, be assured that there were no other problems that had not yet come to light and what could be done to ensure this situation did not arise again. Those workstreams would all require detailed planning that could not be done in a day.

81. Those immediate plans, therefore, needed to focus on:
    81.1. what planning needed to be stopped in a practical sense in the existing facilities (which were, after all, in the advanced stages of preparation for a move and closure)
    81.2. communications
    81.3. making sure patients and staff were going to be in the right place at the right time the following week (including re-arranging staff rotas, etc.)

81.4. what needed to happen immediately in terms of equipment and infrastructure to allow the existing facilities to continue to provide the services.

82. In relation to that last point, it was recognised that spending on the existing facilities had been on the basis that the facilities would cease to be used on 9 July 2019, so it was recognised that immediate steps would be required to address the new reality of the facilities having to continue to provide services.

Events of 5 July 2019

83. I appeared on BBC Radio Scotland on the 5th of July 2019 **(A41231996 – RE_Edinburgh Childrens Hospital – for tomorrow – (Attachment containing Jeane Freeman Good Morning Scotland transcript) – dated 5 July 2019 – Bundle 7 - Volume 1 – Page 86)**. I was asked by the reporter if I overruled NHSL and how they wanted to proceed with the opening of the hospital. I responded that "They hadn't made a decision about what they wanted to do." My position then was that I was aware from the email sent by their Chief Executive, Mr Davison, that he may have been under the impression that NHSL were going to make the decision and were simply informing the Scottish Government. However, in a radio interview, I was not about to throw NHSL 'under the bus'. Not least because people for whom NHSL delivers healthcare need to have some confidence in it. I also did not wish to have any distraction on what was a very serious matter – problems with a major hospital and people not being able to go there as planned. I was not going to create any distraction in the media about the Cabinet Secretary and NHSL having any disagreement.

Events of following days - July 2019

84. The events of 2 July 2019 triggered the DG involving the Scottish Government's Health Resilience Unit (HRU), which as I understand it was tasked with coordinating intelligence and information coming from NHSL. Evidence provided by other witnesses explains the role of the HRU to the

Inquiry. I received emails from the HRU, including an email of 8 July 2019 explaining to me that "Your officials will now operate under a health resilience response…" **(A41022820 – Email from Cabinet Secretary for Health and Sport to Michael Healy on RHCYP delay and update on work undertaken – Bundle 7 – Volume 1 – Page 182)**. The HRU provides support in times of urgent need. They were involved in the immediate aftermath of the critical care ventilation issue being identified until measures were in place to take matters forward on a longer-term basis. They stepped down from this situation on 18 July 2019, see (**A41225838 – Email from Rowena Roche to Barbara Crowe attaching an action list that Health Resilience were maintaining as part of the initial response arrangements around the delay to the RHCYP migration - dated 22 July 2019 – Bundle 7 – Volume 2 – Page 10**).

85. Meetings were held over the weekend of 6th and 7th July 2019 between NHSL and the Scottish Government. I think our representative at these meetings would have been John Connaghan and he would have updated Malcolm Wright, who in turn would brief me. Unfortunately, I can't recall any conversation I had.

86. I believe there had been a DCN migration and feasibility study carried out by Fiona Halcrow at NHSL to assess whether the DCN could immediately move safely as a standalone service into the new building. The conclusion of this study was that no significant issues were identified that would prevent a standalone move of the DCN.

87. At that point, however, nobody could say whether, in addition to the ventilation system in the critical care unit not being adequate, resolving that issue would or would not impact on ventilation systems elsewhere in the hospital. Given the late stage at which the problems with the ventilation system had been identified, I also asked for additional assurance that drainage, water supply and clinical gases met required standards. That feasibility study did not answer those questions.

88. There were too many unknowns in relation to the new facilities. We knew the risks in the existing facilities and the steps being taken to mitigate those. What no-one knew at that point was whether there were other clinical or safety risks in the new buildings – we knew one major risk had been identified at a very late stage but didn't know whether that was the only major problem or what, if any, would be the knock-on impacts of resolving that (or any other problems that might exist). Actually, the point about what it takes to fix the ventilation in critical care, and whether or not that impacts on other bits of ventilation elsewhere in the hospital, is quite an important one because we didn't at that point know what we were going to have to do to fix this and what consequences there might be for ventilation and air changes in the rest of the facility in undertaking the work to get it to the required standard.

89. In those circumstances, you look at balance of risks. That's a big set of unknown risks that we needed to work our way through and bottom out. How do you fix critical care? Is there a risk that whatever is required to fix the problem we currently know about will have an effect on anything else? Are there other problems and, if so, what will be required to address them?

90. You have all of that on one side, and on the other side you have the DCN and Sciennes facilities that are not good, but you know what's wrong with them and you know whether or not you can do anything to make them better in the interim. For me it seemed sensible to deal with what we know rather than shunt people into something where we have no idea what the risks are.

91. That is why I, acting through Alan Morrison, commissioned NHS NSS to undertake a detailed assessment of all buildings systems in the RHCYP/DCN that could impact its safe operation for patients and staff, recognising how infection prevention and control must always be embedded within the design, planning, construction and commissioning activities of all new and refurbished healthcare facilities. I return to this in more detail below, but in brief, this work was to be phased, with assessment of water, ventilation and drainage systems prioritised, including the proposed fix for the ventilation unit. I viewed this report as critical to the determination of the timeframe for migration of services to the

new hospital. I wanted a swift turn-around, so anticipated receiving the full report in September 2019. Running in parallel, I also asked NHS NSS to provide assurance that all current and recently completed major NHS capital projects comply with national standards.

92. It was also important to understand the factors, including information flow and timeframes, which led to the decision, announced on 4 July 2019, to delay the move to the new hospital. That is why KPMG were engaged to conduct an independent audit of NHSL's governance arrangements for the design and build of RHCYP, to provide an external and impartial assessment of the factors leading to the delay. That work began on 15 July 2019 and again I will say more about that below.

Escalation to Level 3

93. On 12 July 2019, NHSL was notified it was being escalated to Level 3 of the NHS Board Performance Escalation Framework (the Escalation Framework) **(A41263551 – Letter to Tim Davidson, copying in Brian Houston, from Malcolm Wright – dated 12 July 2019 – Bundle 7 – Volume 1 – Page 339)**.

94. The Escalation Framework is one of the key elements of the evidence-based approach to monitoring performance and managing risk across the NHS in Scotland. The framework is overseen by the National Planning and Performance Oversight Group, a sub-group of the Government's Health and Social Care Management Board. The framework applies to NHS territorial boards only. Arrangements for national NHS boards are covered by separate arrangements.

95. The Escalation Framework provides five stages of a 'ladder of escalation' that provides a model for support and intervention by the Scottish Government. The wording of the Escalation Framework has been revised over time, but the version in place as of July 2019 is contained in (**A41430802 – Email from Calum Henderson on behalf of DG Health and Social Care to Malcolm**

Wright et al attaching two documents (Board Performance Escalation Framework for NHS Lothian 9 July 2019) and (a letter from Brian House, Chairman of NHS Lothian to Cabinet Secretary for Health and Sport which provides an update on progress on the 2017-2018 NHS Lothian Annual Review 25 June 2019) - dated 9 July 2019 – Bundle 7 – Volume 1 – Page 293).

96. The designation of a board as stage 1 or stage 2 is a policy specific process. Stage 1 is when boards are steady state and on track with their annual delivery plans. Stage 2 is an informal support stage, where the Scottish Government is providing support and guidance, but not intervening in the board. This stage is intended to avoid reaching the threshold for stage 3 or higher. These designations are managed by the Scottish Government policy leads directly with individual boards. A board may be at stage 1 (steady state) in relation to one aspect of its operations and at stage 2 in another.

97. Stages 3 and 4 are formal escalations. This is when requirements for specified action by the board along with enhanced monitoring arrangements are put in place. No statutory powers are being exercised and, as such, the board Chief Executive is expected, in their capacity as Accountable Officer, to co-operate and provide leadership; to ensure the effectiveness and delivery of the Recovery Programme.

98. The decision to move a board to stage 3 is made by the Health and Social Care Management Board (HSCMB) which may be prompted by awareness of a known weakness or the identification of an increasing level of risk in relation to a particular NHS board. The support and interventions at stage 3 are: Formal approach incorporating significantly enhanced support and scrutiny and likely to include a level of external support; Relevant Scottish Government Directors engaged with NHS Board Chief Executive Officer and top team; Director General Health and Social Care aware.

99. In relation to stage 4, the decision sits with the DG Health and Social Care, where consideration of the board's position within the Framework would

normally be prompted by a board failing to deliver on the recovery actions agreed at stage 3 or the identification of significant weaknesses considered to pose an acute risk to financial sustainability, reputation, governance, quality of care or patient safety. The support and interventions at stage 4 are: Senior level external support reporting to an Assurance Board chaired by Scottish Government; Assurance Board reports direct to the Chief Operating Officer for NHS Scotland and Director General Health and Social Care. The onus remains on the NHS board to deliver the required improvements.

100. The decision to escalate a board to the highest stage in the framework is taken by the Cabinet Secretary for Health and Sport with advice from the HSCMB. Escalation to stage 5 involves the exercise of Ministers' powers of intervention under the National Health Service (Scotland) Act 1978. Escalation to stage 5 should not be viewed as part of the normal progression of a board on the framework; it should only be used in exceptional circumstances.

101. The Scottish Government Health and Social Care Directorates Management Board (HSCMB) met on 10 July 2019. They discussed a paper that had been prepared in relation to NHSL, which carried a recommendation to escalate NHSL to Stage 3 of the Escalation Framework **(A41430802 – Email from Calum Henderson on behalf of Dg Health and Social Care to Malcolm Wright et al attaching two documents (Board Performance Escalation Framework for NHS Lothian 9 July 2019) and (a letter from Brian House, Chairman of NHS Lothian to Cabinet Secretary for Health and Sport which provides an update on progress on the 2017-2018 NHS Lothian Annual Review 25 June 2019) – dated 9 July 2019 – Bundle 7 – Volume 1 – Page 286)**. When NHSL was escalated to Level 3, an Oversight Board and Oversight Group were established. The Oversight Board related specifically to delivery of the RHCYP/DCN project and was initially chaired by Christine McLaughlin (Director of Health Finance), then from 10 October 2019 by Professor Fiona McQueen (Chief Nursing Officer). The Oversight Group, chaired by Professor John Connaghan, focused on improving performance across a number of different healthcare deliverables across NHSL.

102. I received a briefing note from Alan Morrison dated 25 July 2019 **(A41230822 – Email from Rowena Roche to Cabinet Secretary for Health & Sport attaching a briefing to Cab Sec to provide an update on RHCYP – dated 25 July 2019 – Bundle 7 – Volume 2 – Page 128)** within which you will note, at paragraph 10, the proposed representation and remit of the Oversight Board. The purpose of the Oversight Board was to oversee the delivery of the RHCYP/DCN project and to provide advice and assurances to the Scottish Ministers. The Oversight Board's terms of reference can be found at Inquiry document **(A41232145 – NHS Lothian RHCYP Oversight Board_ToR – Bundle 7 – Volume 2 – Page 352)**. Christine McLaughlin, as chair of the Oversight Board, prepared the terms of reference and I signed off on those. Those terms of reference define the scope of the Oversight Board's work as:

"The Oversight Board will provide advice in relation to:

- Advice on phased occupation
- Advice on the proposed solution for ventilation in critical care areas and on any other areas that require rectification works
- Advice on facility and operational readiness to migrate
- Gain information and give advice to NHS Lothian about commercial arrangements with IHSL for completion of works
- The approach to NPD contract management
- Identification of areas that could be done differently in future"

103. The original members of the oversight board were:

103.1. Christine McLaughlin, Chief Finance Officer, Scottish Government
103.2. Catherine Calderwood, Chief Medical Officer, Scottish Government
103.3. Professor Fiona McQueen, Chief Nursing Officer, Scottish Government (deputy Diane Murray)
103.4. Susan Goldsmith, Director of Finance, NHS Lothian
103.5. Tracey Gillies, Executive Medical Director, NHS Lothian
103.6. Professor Alex McMahon, Nurse Director, NHS Lothian
103.7. Peter Reekie, Chief Executive, Scottish Futures Trust
103.8. Colin Sinclair, Chief Executive, NHS National Services Scotland

103.9. Alex Joyce, representative from NHS Lothian Joint Staff Side (deputy Gordon Archibald)

104.

105. Attending the Board to provide advice and assurance were:
    105.1. Mary Morgan, Senior Programme Director (from the date of her appointment in September 2019)
    105.2. Brian Currie, Project Director, NHS Lothian
    105.3. Judith Mackay, Director of Communications, NHS Lothian
    105.4. Professor Jacqui Reilly, HAI executive lead for NHS National Services Scotland and SRO for centre of excellence work
    105.5. Gordon James, Health Facilities Scotland, NHS National Services Scotland
    105.6. IHSL would have a representative in attendance on an 'as required' basis

106. The first meeting of the Oversight Board took place on 8 August 2019 and was chaired by Christine McLaughlin. The next meeting was on 22 August 2019. Between 22 August 2019 and 31 October 2019, the board met weekly. The RHCYP/DCN was fully opened on 23 March 2021 and the final meeting of the Oversight Board was held on 8 April 2021.

107. The instigation of an Oversight Board is a well-trodden route for the government and the NHS. I received briefings on the work of the Oversight Board and, in turn, I kept the First Minister and the Scottish Parliament updated, see **(A36610350 - Email from Barbara Crowe to the Cabinet Secretary attaching an update from the Cabinet Secretary to the First Minister – dated 9 August 2019 – Bundle 7 – Volume 2 – Page 376)**, which from paragraph 5 onward discusses the early work of the Oversight Board and makes clear its significance to decision making about critical care ventilation, other ventilation and other building systems issues.

Site Visit on 18 July 2019

108. Malcolm Wright (DG), Catherine Calderwood (Chief Medical Officer), and I visited the existing sites at Sciennes and the Western General on 18 July 2019 **(A41232293 - Cab Sec visit to Royal Hospital for Sick Children (Email chain) – dated 15 July 2019 – Bundle 13 – Volume 3 – Page 95**).

109. Before meeting with the staff, I had a meeting with the Chair and Chief Executive of NHSL. As briefed to the First Minister **(A41225889 – Email from Jack Downie on behalf of Cabinet Secretary and Sport to Stuart Low advising that the attached note from Cab Sec to FM on RHCYP will be sent – dated 12 July 2019 – Bundle 7 – Volume 1 – Page 336)**, I was very surprised not to have had any contact from Brian Houston (Chair of NHSL) up until 12 July 2019 and not to have met with him until 18 July 2019 at a meeting the Scottish Government asked for. There are a couple of reasons for my surprise. One is the Cabinet Secretary, representing the Scottish Ministers, appoints the Chair of NHS boards; and I had always been clear with all board Chairs that I considered them accountable for the performance of their board and the work they undertook. So, given the seriousness of this and that he knew he had met me towards the end of June, at which point no issues were raised (I assume because he was unaware of any issues himself), I was surprised that at no point on the second, third or thereafter had I received either a phone call from him, or a request into my private office for him to meet me, to talk to me about what he understood was happening, what he thought should happen, etc.

110. I didn't think that was the correct acceptance of responsibility by a Chair. Given that I had been a board chair, I knew that I would not have waited that long. I can only surmise he waited that long as it reflected a view that he held, that this was an NHSL matter to resolve and the government, and in particular the Cabinet Secretary, really had no business in interfering with that.

111. My meeting with NHSL's CEO and Chair was brief. I was clear with them what I was doing, why, what other steps I had set in train and what I expected from each of them.

112. The primary point of these visits was, however, to meet as many groups of staff as we could in order for me to explain personally and directly to as many staff as possible the situation, the decision I had made and why, hear their concerns, answer their questions and importantly, hear from them what they believed was needed in existing facilities given they were to continue in use, at that time for an unspecified period. Undertaking this was very important to me. I wanted them to see and speak to the person who had halted the move. I wanted them to hear directly from me why I had done that and, importantly I wanted to benefit from their advice and views on mitigations need in the current facilities. I think it's always better face-to-face than by other means. I think that's more respectful; and it also allowed me to ask them questions and for them to ask me questions, as well as allowing me to see the facilities.

113. It was a twofold response from staff. Initially they were upset, disappointed; but very quickly their focus shifted to commenting that the decision I had taken was right - "it's safer." I received no opposition at all to the decision, which I was a bit surprised at, but that's what health care staff are like. They moved very quickly to the practicalities and to addressing what would make staying there better for patients and families. It gave me an opportunity to ask staff what could be done to improve the immediate situation they and patients found themselves in.

114. We ingathered responses. Some of the responses involved regular maintenance that had been paused because everybody was moving. Our immediate response to that was to say that we would reinstate maintenance – paint and fix what they needed.

115. In Sciennes, staff raised a lot of issues around what could be done to make the family accommodation better in the short term. The most pressing area highlighted to me was the Accident and Emergency (A&E) department. The staff raised an issue in relation to the positioning of a pillar that restricted their

view of patients, which was making it more difficult to maintain observation of patients and making movement around that area awkward. They suggested that if you knocked the pillar down (it did not appear to be load-bearing) then that would make the sightlines and flow easier. That was their problem. If the sightlines and flow could be improved that would improve patient safety and avoid people stacking up with kids that weren't well. The removal of that pillar suddenly created more room and better flow. That was an example where we just lifted everybody's heads up because a thing wasn't in their way anymore. That was the kind of decision-making and judgement that we were making.

116. We also visited the DCN at the Western General site that day and talked to the clinical staff and others there. The overall reaction from staff at the DCN was that people were extremely disappointed and upset but didn't disagree with the decision or push back against it; and went straight-away to practicalities. We asked the staff what would make it better, given they were not immediately moving. We were speaking with them about the possibility of migrating the DCN sooner than everybody else and what we needed to know before we could decide that. Staff had the opportunity to ask questions, to hear my reasoning, to understand what more I believed I needed to know before I could decide things like when they could migrate. Again, I think that's a better way of doing it rather than only sending a written communication of some sort.

117. Neither the existing Sciennes nor DCN facilities at the Western General site were where you would start if you had a blank piece of paper. We would not have been building a new hospital if the existing facilities were adequate. One might question whether it was really any worse to go to the new hospital site with things that weren't working than stay where they were. My answer to that line was that the Sciennes and Western General facilities were deficient in those ways because they had been built at a time when the current standards were not required, but they were coping with known risks and mitigations already in place. I was not about to sign off moving all those patients and staff into a new place which did not meet the standards. What could be the possible justification in doing that? The standards were there for a reason. It was not a choice between a good thing and a bad thing. It was a choice between levels of

risk. I judged that the level of risk of moving to the new hospital before it met standards was greater than continuing at Sciennes and at the DCN. Somebody else might have judged it the other way but that was my judgement. Looking back, even on reflection, I still believe I was right to make the decision to delay migration.

118. I wrote to all staff that day to update them on the situation and thank them for their ongoing patience and continued focus on patient care.

119. There were some specific follow-ups that I recall about improvements that needed made in both sites and I had already given a commitment that the cost of all of this, and any pay promotions that came with moving to the new facility, would be met from the Scottish Government Health & Social Care budget and not come out of NHSL's existing budget. I did not want debate about where the funding would come from to give rise to delay in all necessary steps being taken. My directors made further site visits about the follow-up work that we knew had to be undertaken. Those visits were primarily, as far as the staff were concerned, about seeing a Scottish Government presence more in following through on some of the issues that they had raised with me about what they thought would make working in the existing sites better for them and for the patients. I wrote to NHSL staff again on 30 September 2019 to give them my thanks **(A41231067 – For Immediate Issue_Letter to all staff from the Cabinet Secretary for Health and Sport - dated 30 September 2019 – Bundle 13 – Volume 7 - Page 1023)**.

NHS NSS and KPMG Reports

120. As I mentioned previously, around 8 July 2019 I announced that NHS NSS would be conducting a review in relation to the RHCYP/DCN project. That was to be a two-stage review, with the most pressing need being to focus on the project's compliance with technical specifications. A brief **(A41020525 – Email from Alan Morrison to Cabinet Secretary for Health and Sport attaching a briefing on an emerging issues from NHS Lothian – dated 2 July 2019 – Bundle 7 – Volume 1 – Page 37**) was sent to NHS NSS requiring assurance

as to whether current technical specifications were all in order and that ventilation, drainage and water were all in line with national guidance.

121. All commissioning communication was dealt with by either Malcolm Wright in his role as DG or delegated to his directors. I had asked for the first report from the NHS NSS review **(A41213257 – NSS Report that is a review of Water, Ventilation, Drainage and Plumbing Systems (version 1) – dated 9 September 2019 – Bundle 7 – Volume 3 – Page 373)** as a matter of urgency so that it would be clear what needed to be done first to address the situation that presented. In terms of the level of urgency, I would ideally have wished to see the output from this report in August but accepted that early September met my urgency stipulation in circumstances in which I was asking for a detailed and thorough report.

122. This report, along with that commissioned from KPMG, discussed further below, fed back into emerging thinking about supporting NHSL (with absolutely no disrespect to any individual on the board or its Chief Executive) in this major infrastructure project. This also connects with the thinking about the establishment of NHS Scotland Assure, which I discuss further below.

123. The NHS NSS report **(A41213257 – NSS Report that is a review of Water, Ventilation, Drainage and Plumbing Systems (version 1)– dated 9 September 2019 – Bundle 7 – Volume 3 – Page 373)** can be spoken to in full by a witness for NHS NSS. The NHS NSS report pointed to problems with the electrics, with some aspects of water and, I think, oxygen as well. It was then clear that there was a lot of work that needed to be done.

124. The findings I took from it in relation to management and assurance were:
    124.1. for both IHSL and NHS Lothian, there appeared to be omissions in the identification, appointment, and definition of key roles in an effective management structure
    124.2. some records necessary to demonstrate compliance with appropriate specifications and guidance remained outstanding

124.3. the Board cannot pass its responsibilities under health and safety law to a third party. It can pass duties, but the responsibility for ensuring the safety of those accessing its premises remains with the Board

124.4. to discharge its duties, the Board should ensure appropriate structures and processes (set out in the Scottish Health Technical Memorandum (SHTM) suite of guidance, Statutory Compliance Audit and Risk Tool (SCART) and Healthcare Associated Infection-System for Controlling Risk in the Built Environment (HAI_SCRIBE), produced by Health Facilities Scotland) and personnel are in place to ensure that those responsible for operating the facility are doing so in compliance.

125. The key findings I took from the report in relation to water (all of which were alarming given the situation at QEUH) included:

125.1. "From initial inspection of the Independent Tester's reports, there is evidence that areas of the pipe work systems were installed without end protection. This may have allowed dust and organic material to enter the pipe system and this may not have been eradicated by the disinfection process" **(A41213257 - NSS Report that is a review of Water, Ventilation, Drainage and Plumbing Systems (version 1) dated 9 September 2019 - Bundle 7 – Volume 3 – Page 390)**

125.2. "NHS Lothian commissioned a specialist safety consultant in May 2019 to conduct an overall safety audit of the RHCYP & DCN. Contained within their report is a section on the water system. They assessed the risk condition of the system as "high" mainly as a result of BFM's Legionella risk assessment, the lack of evidence of flushing across the system, the lack of maintenance on shower heads and outstanding information on the water management responsibilities by BFM." **(A41213257 - NSS Report that is a review of Water, Ventilation, Drainage and Plumbing Systems (version 1) dated 9 September 2019 - Bundle 7 – Volume 3 – Page 390)**

125.3. "management aspects of the water system by IHSL's FM contractor were not satisfactorily demonstrated. The system showed signs of biofilm and swarf contamination, particularly at the taps. Shower heads

and hoses do not meet the required standards with respect to length." **(A41213257 - NSS Report that is a review of Water, Ventilation, Drainage and Plumbing Systems (version 1) dated 9 September 2019 - Bundle 7 – Volume 3 – Page 391)**

126. The key findings I took from the report in relation to drainage and plumbing (again alarming, given the situation at QEUH) included:
    126.1. The connection on to the wash hand basin from the drain has proven to be an area where water does not drain freely, creating a dam effect where various organisms may grow in some circumstances. **(A41213257 - NSS Report that is a review of Water, Ventilation, Drainage and Plumbing Systems (version 1) dated 9 September 2019 - Bundle 7 – Volume 3 – Page 392)**
    126.2. The Independent Tester noted in their report of 30th June 2017 "that an issue had been raised regarding the capacity of the basement sump. In further investigation this appears to be related to the fact that more areas/floors were connected to this system than NHS Lothian had originally been made aware of. The main drainage risk lies with the basement sump." **(A41213257 - NSS Report that is a review of Water, Ventilation, Drainage and Plumbing Systems (version 1) dated 9 September 2019 - Bundle 7 – Volume 3 – Page 393)**
    126.3. "In the event of a catastrophic blockage and spillage the court yard would be impacted." **(A41213257 - NSS Report that is a review of Water, Ventilation, Drainage and Plumbing Systems (version 1) dated 9 September 2019 - Bundle 7 – Volume 3 – Page 393)**

127. I felt the results from the NHS NSS review, to an extent, justified my decision. I wasn't particularly looking for justification though. My focus was upon what we needed to do next. Actually, if I recall, asking them to look at gases was an issue that came from discussions with the trade unions. They said they had raised the whole question of clinical gases, and the safety of those and the adequacy of those, with NHSL, but they still weren't convinced, so I think we added that in to check as well.

128. The NHS NSS report gave us a view of the scale of the number and scale of the issues that needed to be addressed and also, if I recall correctly, an assessment of which ones were really important and which ones could be fixed after occupation. I was clear that, as a lesson learned from the QEUH experience, I did not want major retrofitting going on once the hospital was occupied. Better to hold back from moving for a little longer and fix it before people go in, than have a situation where patients were in, but there would be scaffolding and all sorts of construction going on.

129. The NHS NSS report mentioned the Haematology and Oncology department (The Lochranza Ward) regarding the 10 air changes per hour requirement. I wasn't aware of any issues with that before this report, but I think it would be the Chief Medical Officer who would have asked that that ward be particularly checked (again given the experiences at the QEUH).

130. I asked for the NHS NSS report and the KPMG Report to be published at the same time. There was no particular reason for this not to happen. It gave everyone a timescale to work to and I was keen to be able to obtain information as quickly as possible. Thoroughness, clarity, and quality of work were the drivers and, if that could be achieved in parallel to allow publication at the same time, that was an added benefit. The sooner we could produce this information for Parliament, and to the wider public, particularly the Edinburgh based public, the better. It would then allow us to work out some necessary actions, including the key one of what was needed to make this hospital safe. In parallel to that were other important aspects, including how long it might take and what it might cost.

131. The KPMG report was helpful too. It found that, essentially, what had happened was human error. Again, I wanted to make sure that every Chief Executive knew and were double-checking they had spelled out everything clearly if they had infrastructure projects.

132. The point of KPMG, and also the report from Audit Scotland who became involved as well, was to provide that level of independent scrutiny of what was

happening for my benefit. It was an additional layer of assurance outside of government and the health service. When something big has happened that is unexpected and is a problem and affects individuals, they are never overly assured if what they see as one bit of the same body, reviewing the bit that didn't seem to get it right. People always worry that you're just covering things up or you're not scrutinising it well enough.

133. I relied quite heavily on each of the reports' findings to help me inform my thinking on next steps.

134. After the reports were published, I was advised against the removal of both the Chair and Chief Executive of NHSL **(A41231780 CSHS – Submission – 10 September 2019 – RHCYP Governance and Accountability Issues (002) – SGLD – 10.09.19 – Bundle 7 – Volume 3 – Page 432)**. The Cabinet Secretary can't remove a health board's Chief Executive because it's not the Cabinet Secretary who employs a Chief Executive, or any of the executive directors. It's a board that does that. The means by which government can intervene is through the DG/Chief Executive of the NHS who can remove accountable officer status, which then requires a board to review the Chief Executive's position. Even then they don't have to remove their Chief Executive. They can find a workaround if that's what they wish, although it's a pretty strong signal. Where the Cabinet Secretary has a locus is in the Chair's appointment because it is the Cabinet Secretary who signs off the appointment of chairs and non-executive directors. I didn't have a view that either should go, as a definite view, but it was an obvious question that needed to be considered.

<u>Escalation to Level 4</u>

135. On 13 September 2019, NHSL was escalated to Stage 4 of the Escalation Framework in respect of the RHCYP/DCN project **(A41231071 –Letter MW -B Houston and T Davison – NHS Lothian Level 4 Escalation –Sept 2019 – Bundle 7 – Volume 3 – Page 564)**. NHSL stayed at Level 3 for all other purposes, so the escalation was solely in relation to the RHCYP/DCN project. The decision to escalate to Stage 4 rests with the DG and I was briefed

accordingly. I agreed with the escalation. As a result of this escalation, Mary Morgan was appointed as Senior Programme Director to oversee the safe delivery of the project.

136. She was recommended for the post by the DG **(A41231824 – Email from Alan Morrison to the Cabinet Secretary and Christine McLaughlin providing a further urgent briefing – dated 10 September 2019 – Bundle 7 – Vol 3 – Page 533)** and **(A41231071 – Letter MW - B Houston and T Davison – NHS Lothian Level 4 Escalation –Sept 2019 – Bundle 7 – Volume 3 – Page 564)**. Again, I did not disagree and if I had thought for whatever reason that this would not be a good appointment then I would have said so. I made it clear that we needed such a person in post.

137. Mary Morgan's role as Senior Programme Director was to ensure that everything that needed to be done to make the hospital safe to open was done. She had the necessary skills to be able to work constructively with NHSL, bearing in mind there was a tension there, and also with contractors in order to get the best out of them; and do that with the understanding of when to flag issues that really government needed to know about. She was to have a strong input into what she thought the timeline would be towards migration, based upon what she had done to understand everything that needed to be done, to talk to everybody that needed to be talked to.

138. Mary Morgan reported to the Oversight Board via her Senior Programme Director's Reports. She was a standing attendee at Oversight Board meetings in order that she could advise on progress and anything she was concerned about. Her reports updated on matters such as NHS NSS having produced a report on water and the pseudomonas had been eliminated or dealt with. She provided a rationale for her recommendations and set out the issues being dealt with in a helpful red, amber, green (RAG) format, which was easy to follow. She was a key member of staff who oversaw the delivery of what needed to be done.

139. The Oversight Board also had representatives from NHS NSS, including Health Protection Scotland (HPS), and Health Facilities Scotland (HFS), so I knew that those with the right expertise were feeding into that Board and the reports and recommendations I was receiving from it.

140. Once the Oversight Board and Senior Programme Director were in place with their remits and responsibilities, a regular pattern of reporting up the line was in place and decision-making became more formalised. From that point onward, until the project completed, my role was primarily to receive updates from those with the necessary technical expertise; to be satisfied that they were providing the level of assurance I was looking for; and take the high-level decisions as and when necessary. I received a copy of the papers for meetings of the Oversight Board and in addition was provided by my officials with regular briefings that summarised the key issues and progress being reported through the Oversight Board.

Supplementary Agreement 2 (SA2)

141. The contract to build the hospital was held by NHSL with IHSL and through them onwards to the contractors. How the additional work would be done needed to be commercially negotiated. The output of those negotiations was Supplementary Agreement 2 (SA2). I had no locus in those commercial negotiations other than to be reassured that what I required to be done was going to be done. It was agreed that the Scottish Government would meet the additional costs, once quantified, and assured by my finance officials. I had already made a commitment that the Scottish Government would fund any additional costs incurred to bring the hospital to the standard that we needed for it to be safely opened.

142. I have been asked if I had any frustrations surrounding how SA2 was progressing. Yes, I did a little bit. However, I also understood it because the parties were seeking to protect themselves from liability. Whether I thought the way they were seeking to protect themselves, or to limit their liability, was reasonable or not was irrelevant. I understood what they were doing and why

they were doing it. I just needed them to get on and conclude it because it was holding things up. We relied a great deal on Mary Morgan's negotiating skills to get people to that point. What Mary Morgan was partly doing was looking to see where we could minimise delays through obtaining agreement from contractors to move certain things forward. There was a point where, even though the final agreement was not signed, IHSL agreed to go ahead and commission the necessary equipment to upgrade the ventilation system anyway. All of that was to her huge credit. Inevitably, however, there were some delays we just could not minimise and had to live with.

143. All of this was delegated to the Senior Programme Director, Mary Morgan, and overseen by the Oversight Board. My job was to be confident that I was being kept up to date with progress, the timelines, and the attached risks. I received regular updates, through my officials, Ministerial Briefings (all of which have been provided to the Inquiry) and through the Oversight Board papers, which were copied to me. All of this was to ensure that I knew what progress was being made and whether it was, by and large, on track. I could then ensure that the First Minister and, where appropriate, Parliament were made aware of any developments. It would be then through Parliament that constituents would be made aware of what had occurred. It is important to be clear here that, whilst my role was not a passive one, it was important to let those with specific responsibilities get on with exercising those responsibilities. My role was to ensure I was completely up to date, including with any problems as well as progress and, where I felt it necessary, to challenge matters, suggest ways to overcome problems, and encourage progress.

Phased Migration

144. I was kept up to date throughout as to whether there was any opportunity for phased migration. That was particularly so in the earlier days around the DCN which, at that time, was in the Western General. Whilst the hospital at Sciennes could continue to deliver safe patient care with some of the modifications we had agreed that it needed, it was clear that the DCN was in a more difficult

building. If it was possible to move the DCN in any phased way, then it was preferable we did that as soon as possible. There were huge complications with timelines around buildings being brought up to standard and being assured about standards. There were then practical considerations that needed to be accounted for like staff rotas, inpatient appointments and so on. The Oversight Board and Mary Morgan were overseeing and leading on all of that.

145. As already explained, the Oversight Board was chaired initially by Christine McLaughlin and subsequently by Fiona McQueen. They understood very well what the big drive for me was **(A41232145 – NHS Lothian RHCYP Oversight Board_ToR – Bundle 7 – Volume 2 – Page 352)**. That was to ensure that everything that needed to be fixed was fixed. I didn't want a hospital opened where major infrastructure had to be retrofitted. I wanted the facility to be fixed to the appropriate standards so we could be confident it was safe and then get the people in there. If you do not open a hospital because it is not safe, you can't compromise on getting it to a point where it is safe.

146. Clinical input from day one is essential. We have good examples of where clinical input from day one is effective. We have seen it in the design and build of the extensions at the Golden Jubilee Hospital. It was part of what came forward as a proposition for the replacement of Monklands General Hospital. Clinicians are the only ones who can know things like how patient flow works. They are critical at the outset but, at the same time, they are not architects or builders. You cannot put everything on their shoulders.

147. I have been asked by the Inquiry to what extent was I influential as to the phased migration period for the DCN. The people who needed to be most influential in the phased migration were the clinicians and the whole healthcare team in the DCN. Those people were the people who best understood both the level of seriousness of the situation for the patients they were caring for and the practicalities of moving in terms of that safe patient care. They had to be, if you like, the primary people consulted on what they needed to be assured of where they were going to, and their capacity to do a phased migration.

148. My role was to be sure that those people were being consulted before finally agreeing whatever the plan was that came forward. I needed to be assured that plans for taking matters forward were fit for purpose. I signed off every phase of the migration, see for example **(A41477155 - HIS Inspection of Sick Kids – dated 07 October 2019 – Bundle 13 – Volume 3 - Page 102)**.

149. I was dealing with the unions in parallel. That provided me with, if you like, an additional assurance. I would hear where things were not correct and whether the clinicians and healthcare staff were content.

150. Delays were incurred because of COVID. Although part of our response to the pandemic was to require construction work across the country to pause, we had given exceptions to healthcare facilities. However, there were still delays due to disruption to supply chains, the need for social distancing and so on. Construction, even in an approved site, could not proceed as quickly as it might otherwise do because workers had to abide by social distancing requirements. You could not have a bit of a building with electricians, builders, and plumbers all in there as they might otherwise be. Also, staff in the Western General were being redeployed to cope with the anticipated demand from the pandemic so, inevitably, there were delays caused through that. That all delayed everything.

The Development of NHS Scotland Assure

151. The responsibility for delivery of healthcare projects lies with health boards and it is for health boards to ensure that they put in place sufficient technical resource to deliver those projects. I have sympathy, to a degree, with the executive directorship of a health board when asked to deliver a major infrastructure project when they have principally been appointed to deliver healthcare, to manage budgets, to ensure that healthcare is safe and effective, to recruit staff, etc. They are not appointed to be technical or construction experts; and for any Chief Executive it will probably be a once in a career task to deliver a major project such as the construction of a new hospital. However,

they appoint external advisers to provide the expertise and advice they need. That is what NHSL did.

152. What we did not have and what I thought would be useful to health boards in dealing with infrastructure projects, was essentially a single place that they could refer to for the expertise, advice, and guidance that they could follow, regardless of whether they had been in charge of a major or minor infrastructure project at any point in their career. Such a body would itself grow in expertise through experience, could look at design and build elsewhere in the UK and beyond and could, critically, ensure that infection prevention and control would be key drivers in the design and build of all healthcare facilities. This all led to the establishment of what is now known as NHS Scotland Assure.

153. NHS Scotland Assure was also, from my point of view, a place where the Cabinet Secretary could go to look for expert opinion and assurance, a place which took responsibility for ensuring that all standards were being met, and where actual physical checks were being carried out.

154. We needed to move away from a situation where individual health boards had responsibility for the design and build of major healthcare infrastructure but did not have a single central point of support to which they could turn for all relevant infrastructure design and build experience and expertise. That was partly because it was showing itself, through the QEUH and RHCYP/DCN projects, not always to work. I do not think you can have major healthcare infrastructure designed and built at a cost to the public purse without a clear line of accountability and, in my view, that can only come through a Minister of Government. In some instances, it is the force and nature of your personality that inserts yourself in a project. I think, to an extent, this was the case with the RHCYP/DCN project. There was no question in my mind that I, rather than NHSL, was now responsible for the successful delivery of the RHCYP/DCN project. Other Cabinet Secretaries might have taken a different view, and they could reasonably argue that they would have been legitimate to do so, because of the way in which contractual arrangements and responsibilities work.

155. I took the view that you need to pool the expertise into a central place and make it clear what Government is responsible for. That became clear to me following 2019. I remain definite on my view on that now.

156. One of the things that became clear in NHSL RHCYP/DCN was a lack of physical testing. I thought that what was needed was, as I termed it, a clerk of works – someone with a clipboard who would physically go around pressing a button to see if it works. That did not happen with RHCYP/DCN; things were done on basis of paper assurances. That self-evidently did not work; so the creation of NHS Scotland Assure was part of me trying to get my clerk of works: the person that nobody ever wanted to see, that prodded and pushed buttons and just made sure that if they said the ventilation system meets the standard, they have actually checked it and not just looked at bits of paper.

157. I made an announcement about it to the Scottish Parliament on 19 September 2019, at the same time as my statement about the NHS NSS and KPMG reports **(A41229927 – DH Statement 190911 – dated 11 September 2019 – Bundle 7 – Volume 3 – Page 544)**. It had been under consideration from an earlier stage though, and for me, in particular, in light of my experience at QUEH. The briefing to the First Minister of 5 July 2019 **(A41020453 – Edinburgh Children's Hospital – Note from Cab Sec to FM – Bundle 7 – Volume 1 – Page 118)**, has a section headed "Role of HFS in all future builds for NHS Facilities," and notes that my officials had, that day, received a proposal from NHS NSS that was being reviewed. The importance of moving this forward was underlined as the issues with RHCYP critical care ventilation came to light (see action list maintained by Health Resilience within the Scottish Government as at 18 July 2019, which included the following entry (number 18): "Provide acknowledgement to NSS to proceed to the next stage of development of the Centre of Expertise on Infection Control" **(A41225838 – Email from Rowena Roche to Barbara Crowe attaching an action list that Health Resilience were maintaining as part of the initial response arrangements around the delay to the RHCYP migration - 22 July – Bundle 7 – Volume 2 – Page 12)**.

158. The establishment of NHS Scotland Assure was to my mind, therefore, very much a response to events at the QEUH and RHCYP/DCN.

Reflections

159. Prior to the critical care issue coming to light, NHSL had signed off on the build and taken control of the site. That triggered the monthly unitary charge of circa £1.35 million payable by NHSL to IHSL. Had the testing against the standards been done properly, then NHSL might not have taken ownership of this site because it wasn't 'to standard', in which case, it wouldn't have triggered these payments. However, there was a contractual obligation. It's a galling cost to the public purse to be paying for something that couldn't be used, as well as the additional cost that would be incurred to get it to the necessary standard.

160. I had already said that the Scottish Government would cover the additional costs, because I wasn't prepared to get into an argument about taking money out of NHSL's budget. Inevitably what that means though, and I think I was clear about this to Health Board Chairs and Chief Executives and certainly in the Scottish Parliament, is that if we were spending that additional money on RHCYP/DCN because of what had happened here, then that was money that was no longer available to spend elsewhere on healthcare.

161. It was clear to me that what had been done on the RHCYP/DCN and QEUH projects was not good enough. The problems uncovered on those projects did initiate some of the changes that have now been put in place.

162. One of the clear actions that I think would have raised this issue much sooner is a closer scrutiny and greater clarity in the contractual requirements. Another is that the testing of whether or not standards have been met is actual physical testing, not something that's undertaken as a paper exercise.

163. Those are not criticisms necessarily of what people did or didn't do because they did what was always done. In fairness, there were other infrastructure projects, including major hospital builds, which proceeded in the same way, to

the same format and that opened without any issues with standards or safety and opened on time and, from memory, on budget (for example, in Orkney and Dumfries and Galloway). Those were major builds in those areas, so it can't be said exclusively that the old system was at fault, because it self-evidently worked fine in some places. One might say that the problems with the RHCYP/DCN project arose because NHSL 'messed up', but I think it is hard to then say there's nothing wrong with the old system. This is a small country. Infrastructure builds, particularly in healthcare, are absolutely critical. They must be safe. Standards change and improve all the time, so you need a repository of expertise and knowledge that health boards are required to use. I emphasise 'required to use', and, beyond that, government looks to see that what you are doing as a board has been assured by that repository of knowledge and expertise and that repository is actively engaged in what you're doing.

164. The alternative is to say that all infrastructure build in healthcare is only done by that central body but, that cuts right across the obligations of local health boards, so you need to find a way of balancing that, which was the intent in all the other stuff that was then done.

165. I am very grateful that that independent validation identified the issues within the hospital. I think everybody should be grateful about that. What would have happened without it would have been that we would have migrated everybody into the new hospital with lots of 'hurrahs', and then pretty soon our clinicians would have said, "Wait a minute. This isn't what it should be," at which point we would then have had to decant people. We would have started having a construction site inside a hospital, with all the risks, disruption and uncertainty and anxiety that that brings to everybody. You can't then have critical care. Where would you then have it because you've just sold off Sciennes. So, the consequences are horrendous.

166. There is something here that I think is quite important that we shouldn't miss, and that is the importance of clinical input to the design and construction of healthcare facilities. Whilst a clinician operating in critical care will not

necessarily know what ought to be the case in theatres, or in another ward, they will know what they need in critical care. They will know what should be happening there, just as the theatres teams will know. So, you need to find a way to have their input into the design and compliance with the standards. This isn't hard. We have seen it elsewhere in NHS Scotland. It's about spending time with clinical teams at the design stage, so you have all that's needed where it is needed before you build. We find better outputs where that is done, alongside the critical input of expertise on standards.

167. As far as how NHSL handled matters, I think they attempted a version of, "Nothing to see here. We can fix this, and everything can just go ahead." Whilst I might understand their motivation for doing that, it's all about reputation and perception. I think it was a fundamental flaw on their part because their first and foremost responsibility is patient safety. If that means that, in pursuing that, your reputation is dented a bit, so be it. So, I don't think NHSL handled it well.

168. As far as how the Scottish Government handled issues when they came to light, I think we got the primary decision right. We got all of the things that needed to happen done to communicate that decision to those that were most affected by it. I think we got the follow through actions right. I suspect (and I would arguably concede this) that NHSL may say that I was too high-handed, and that's possibly how they perceive what I was doing. I would accept that that was their perception. I wouldn't change what I did.

169. In terms of pace of information, I think it's fair to say that the Health and Social Care Directorate was used to the fact that I like things to happen quickly. That's not to sacrifice all the information needed; it just means I need the information quickly. So, in terms of how quickly the Directorate responded and how quickly they could find things out for me and give me their views, they moved at the fast pace I needed them to move. Where they may have struggled, in some instances, was getting information from NHSL. For example, the question of when that validation test actually happened feels to me like a really straightforward question. Somebody somewhere must have had it in their diary

and yet there was an awful lot of to-ing and fro-ing trying to get hold of that information.

170. In that sense some things were slower than I needed them to be but, in terms of how quickly the Directorate moved, then they were keeping pace with what I wanted. Where they thought that they could not respond as quickly as I wanted, I think we had a quality of relationship where they could explain that and set out what was possible. Also, of course, in July we were in holiday period, so sometimes things aren't as quick as you might want them to be but, by and large, I think I got all of the information I needed as quickly as I needed it, and where I didn't get that, there was a reason for it.

171. I think the Scottish Government has to move away from a notion of being arm's length to all of this, facilitating the funding, but basically leaving it then to boards to get on with it. I think that's unrealistic but also wrong. It's unrealistic because at the end of the day, whoever is Cabinet Secretary is going to be accountable to the Scottish Parliament. You can't be accountable for things that you're out of the loop on, but at the same time you are still accountable in that way. It's also not sensible because we're talking about significant sums of public money alongside, in healthcare, people's safety and the quality of the care that they receive.

172. I think what you need to have is a body of expertise and knowledge in everything to do with the safe and effective construction of health infrastructure that is accountable to the Scottish Government and mandated in its use by health boards. That way you've got a more direct line into what's going on and a more direct line of accountability, but also you are now giving health boards access to a resource that they would not otherwise have access to all in one place.

173. We don't need loads of experts, but we need experts. Also, they can, as part of what they do, not just make sure that everything complies with standards, but they can contribute to the development and the improvement of standards by applying their knowledge so that you are constantly looking to make sure that

everything is not just as safe as it was yesterday, but as safe as you need it today because you've improved things. Giving the obvious example of 10 air changes per minute, a group of clinical experts will have come up with why that needs to be like that. They may change that in future, in the light of future knowledge; you need to be up-to-date and contributing to that.

174. In terms of reporting information and record-keeping I think there is a more active role for a central organisation in prodding that kind of reporting. That is what I think that central organisation (now NHS Scotland Assure) is there to do, because that then alters the relationship between government and health boards. By that I mean, you have NHS Scotland Assure and it does what I described I think it should do, so it is now the body that is prodding; and it's now the body giving assurance to the Cabinet Secretary because it has gone in and poked stuff, and it's confident about standards being met and patient safety being paramount.

175. When I talk about these people being experts, both in NHS Scotland Assure and any independent experts called in for a specific purpose, they absolutely are, and so they don't really care about the politics of anything. They are construction engineers and are focused on providing assurance that, for example, the ventilation system is meeting standards. That means you can have confidence that they have gone and poked it they didn't just accept a bit of paper. That is not to say that the role of independent external experts and advisors is not also important – they absolutely are.

176. I think that the actions undertaken to remedy the defects were adequate and have resulted in a safe hospital. There were several lessons learned surrounding the design and build of major healthcare infrastructure and how you go about doing that. It is important to recognise that there have been other hospitals designed and built, both before and since the RHCYP/DCN, that did not have the sorts of problems experienced on that project. Balfour in Orkney and Dumfries Acute Hospital were built in the same period and none of the difficulties encountered on the RHCYP/DCN project were encountered on those

projects, and there were no significant delays to their openings. I do not think that every bit of major healthcare infrastructure that has been designed and built in the most recent period needs to be looked at again, provided the assurances sought and noted earlier have been given. However, just because we have projects that have gone well doesn't mean that we should ignore those that haven't gone so well.

177. Part of the rationale for not letting the RHCYP/DCN open was that I knew, from experience, that retrofitting does not work for something as critical as ventilation. I had seen that on the QEUH project. You did not need to be a construction expert to realise the scale of the interruption to services, safety and infection control issues that will arise when you have to take down ceilings and put in new ventilation infrastructure. You run the risk of airborne particles that can be harmful; you create noise and disruption in settings where calm is critical to patient care; and you create anxiety amongst staff and patients with respect to actual or perceived increased infection risks. Trying to do such major infrastructure work in a hospital full of patients is just not possible and would have required decanting (something that is also no small consideration, again as we have seen in the QEUH).

178. I would say, finally, that NHSL worked extraordinarily hard and well during the difficult circumstances of COVID. Notwithstanding anything else I might say about NHSL, I think it is to their credit that whilst they may not have been overly happy with the decision not to open the RHCYP/DCN on the date that they had planned, people basically just got on with dealing with the situation that they had to deal with. The same can be said in relation to their working with Mary Morgan. No Board likes the idea that they are at a heightened level in the escalation framework. No Board likes the idea of an Oversight Board overseeing them, working with a Senior Programme Director appointed by the Scottish Government at Stage 4 of the Escalation Framework, reporting directly into the Scottish Government. That is not a comfortable place for any health board to be. It is to NHSL's credit that they just swallowed, breathed deeply, got on with it and did very well. Notwithstanding the commercial issues and COVID,

they achieved the ultimate goal of delivering a hospital that now ranks amongst the safest in Scotland, Europe, and the rest of the world.

Declaration

179. 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.