SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
9 May 2022

Day 7
Wednesday 18 May 2022
Brian Currie

CONTENTS

11:00

THE CHAIR: Good morning, everyone. Before I ask our witness to be brought in, can I just say something about the way – well, I say "we" dealt with, responsibility is entirely mine – we dealt with Mr Ellis's request to ask questions on Monday? Reflecting on what I did, I think perhaps I should just clarify what I would expect to happen in future. On Monday, Mr Ellis wanted to ask some questions of Mr Baxter. He had a discussion at the desk with Mr McClelland, Mr McClelland indicated that he was not inclined to ask the questions, and what then happened was that I simply invited Mr Ellis to ask his questions.

Now, no criticism of Mr Ellis, no criticism of Mr McClelland, all the criticism points in my direction because, when one looks at rule 9, what I should have done at that stage is to invite Mr Ellis to have made an oral application in terms of rule 9. So departure from a procedure which should have been followed, responsibility for that departure is mine. Just to clarify, it is not that I am in any way innovating on what has been previously said, but if or when such a situation arises in future, we will ask the witness to leave the Inquiry or the hearing room for the moment and I will hear a formal application, which I will then consider. Depending on the way that that is decided, then the legal representative may be able to ask questions. So, my apologies and we will try and keep to the procedure in future.

So, with that, Mr MacGregor, we are in a position to lead Mr Currie.

MR MACGREGOR: Yes, my Lord.

THE CHAIR: Right. Good morning, Mr Currie.

THE WITNESS: Good morning.

THE CHAIR: Now, as you appreciate, you are about to be asked some questions by Mr MacGregor QC, who is sitting on my right. Before then, can I ask you to make an affirmation?

THE WITNESS: Yes.

CURRIE, Mr BRIAN JAMES

(Affirmed)

THE CHAIR: Thank you very much, Mr Currie. Now, the plan this morning will be to sit until one o'clock when we will take a break for lunch. But should you wish to take a break for any reason whatsoever before then, just give an indication to me and we will take a break. The other thing is the microphone should help you. I think one probably has to direct speech at the microphone, but maybe

just keep your voice up a little beyond what you would normally use in conversation.

A Yes.

THE CHAIR: Thank you. Now, Mr MacGregor.

MR MACGREGOR: Thank you, my Lord.

Questioned by MR MACGREGOR

Q Mr Currie, could you tell the Inquiry your full name, please?

A Brian James Currie.

Q Are you employed as a senior programme director with NHS Lothian?

A I am, yes.

Q Now, you have provided a witness statement to the Inquiry, which is found at pages 201 to 223 of the bundle and an appendix at pages 223 to 231. Could I ask you to have your statement in front of you, please?

A I have it here, thanks, yeah.

Q If we could look to paragraph 2 of your statement, approximately four lines down, you will see a sentence beginning, "I have been asked to provide". Do you see that?

A I do, yeah.

Q It says:

"I have been asked to provide a written statement to the Scottish Hospitals Inquiry (SHI) in relation to my involvement in the Project from the commencement up to the start of the procurement exercise."

Do you see that?

A I do.

Q So, just to be clear, Mr Currie, I am going to ask you questions about that part of the project in terms of the chronology. You have helpfully provided the Inquiry with clarification in terms of your views on certain other issues within your statement – the procurement exercise, the contract. I am not making any criticism. It is just simply to let you know that those issues will be explored at later stages of the Inquiry. So, just if we don't cover those today, it's not that we are going to avoid coming back to them, it's just that they are not for today.

A Understood, yeah.

Q Your statement is going to provide part of your evidence to the Inquiry, but I'm going to also ask you some questions today. I should say it's not a memory test. You clearly say in your statement that a lot of the underlying events took place a significant time ago. If you want to look back to your statement at any

point, please do just let me know.

A Thank you.

Q If I could begin with your background and experience, you tell us at paragraph 3 of your statement that you qualified as an architect, is that correct?

A That's correct.

Q So in the 1980s, you worked as an architect in private practice and then thereafter moved into working on construction projects.

A That's correct.

Q Can you just explain to the Inquiry when you moved away from working solely as an architect into construction projects, what type of work were you undertaking at that stage in your career?

A I joined a national retail bank as an architect actually. That was the label, and it quickly changed to a project manager, as was the trend at that time. In the latter days in private practice, I was-- it was a management role anyway more than anything. So I moved into general project management at that time of a corporate company's estate.

Q In terms of project management, on a day-to-day basis, what would you be doing?

A It's principally about managing people and about managing processes. So it's about managing a team, building a team, leading a team or teams, depending on the size of the programme or projects, organising stakeholders, making sure that they're part of the project. So it's about people and about processes, so the end-user input to the project, value management, change management, risk management, communicating, reporting, basically keeping the wheels moving of any project or series of projects within a programme.

Q You then tell us that, prior to joining the NHS, you worked for Lendlease Projects, is that correct?

A Prior to joining the NHS, yes.

Q Can you just explain to the Inquiry when you were working for Lendlease Projects, what was your role and what were you doing?

A The role was really running the Scottish side and the Newcastle area/northeast of England offices. There were three project offices made up of project managers and I was the person running, as Regional Director, those three offices and the staff. So it was chasing work, chasing invoices, that sort of thing. So it was very much the business management end of it.

Q You tell us within your

statement that at that point in your career you were involved in a number of complex construction projects, including, for example, the Royal Bank of Scotland's Gogarburn Campus.

A Yes.

Q You state at paragraph 3 of your statement that you've got "significant experience of delivering high value and complex construction projects".

A Yeah, I've had a very varied background in terms of sectors that I've worked in, from commercial retail banking through leisure, hospitality, healthcare, residential, rail infrastructure, and also working on the client side, civil side and the contractor side.

Q You tell us within your statement, particularly at paragraph 54, that in August 2009, you joined NHS Lothian. Is that correct?

A That's correct, yeah.

Q We will come on to deal with the work that you did in 2009 whenever you joined NHS Lothian. But, in terms of your current role, are you still with NHS Lothian?

A I am, yes.

Q What does your current work for NHS Lothian involve?

A NHS Lothian have just embarked on a major projects programme where there are three large projects at different stages, which I am leading as Senior Programme Director. So they are the Edinburgh Cancer Centre, the Edinburgh Eye Pavilion, or Eye Hospital, and a new National Treatment Centre at Livingston.

Q So three healthcare projects that you are working on at the minute and, I am sorry, was it a project management role that you said you are doing in those roles?

A Yes. My title's Senior Programme Director. We have just recruited teams, project management teams, into the service for each of those projects.

Q Who within NHS Lothian would have appointed you to those projects?

A The company executive. So my main reporting line is through the director of finance and through the SRO, senior responsible officer, for those projects.

Q Thank you. Now, if I could just ask you some questions about when you joined NHS Lothian in 2009, what was your title and role at that point?

A My role was as project director for the then Sick Kids Hospital project, which was a capital-funded

project. It had received an OBC, I think, in 2008, a framework contractor had been appointed early 2009, and the health board were needing to bring in more resource into that project.

Q Okay, so you join NHS Lothian and you are working on the re-provision of the Royal Hospital for Children and Young People and the Department of Clinical Neurosciences. Is that right?

A That's correct, yeah.

Q I will just refer to that as "the project". So if I'm referring to "the project", that's what I am referring to, the Royal Hospital for Children and Young People and the Department of Clinical Neuroscience.

A Yes.

Q In terms of the chronology, if you are joining in 2009, the Inquiry has heard evidence that the initial agreement was 2006 with the outline business case being produced in 2008, and you are then joining in 2009 after the approval of the outline business case when it's a capital project at that point.

A Correct, yeah.

Q Who did you replace as project director?

A It wasn't so much replace, I seem to recall. There was a project director in that role. The lady in question was very much of a clinical background. When I came in – I'm not from a strictly clinical background, obviously – I took on the role of project director and I think we titled her role something like "Clinical Project Director". So it was very much a complementary skills, as most projects are, within the team. So I was heavily involved in the direction of the project in terms of construction and delivery and procurement, and Isabel McCallum was the lady in question, she was the main interface with the clinical teams and the service.

Q So, just so I can understand it, in the period up until 2009, there's effectively been a clinical lead as project director?

A Yes, that was my understanding.

Q Then, from 2009 onwards, after there's been approval of the business case, you are coming in as someone who's got more of a construction background. Is that fair?

A That's correct.

Q Could you just explain to the Inquiry, in your role as project director, what are you doing on a day-to-day basis? What does that role involve?

A I think I mentioned it earlier when you asked what I was

doing prior to NHS Lothian. It is very similar. It's project management, it's about people and processes. So, at the risk of repeating what I said earlier, it's about initially building a team, strengthening that team, leading and managing the team of complementary skilled professionals coming from quite a varied background, a huge range and variety of stakeholders on the Kids project. It was a-- Well, it's an Edinburgh project, it has regional and certainly national implications. Then the processes, project management is about managing processes, and I listed them earlier, you know, from risk to-- risk management-- I can't remember what I said now, but there's a whole list of processes in there.

Q Who are you reporting into?

A I report to the director of finance as my line manager.

Q If I could ask you to have in front of you, please, within the initial agreement-- now, the initial agreement starts in bundle 3, volume 1 at page 95, but it is just an organigram that I would like to take you to, so it is bundle 3, volume 1 at page 109. So, you should see in the top left-hand corner it will say "Appendix 3", but there should really be a whole series of boxes, starting with "NHS Lothian Board". Do you see that?

A I have it here, yeah.

Q So, if you just assist the Inquiry, at the very top of the organisation chart, we have got the "NHS Lothian Board", below that, we have got the "Executive Management Team", below that a "Strategic Change Programme Board" and then leading down towards a "Project Board" and a "Core Project Team". Were you involved in the core project team?

A Yeah. I think that would be the project team, as I would see it, yeah. I've not seen it referred to "core project team" for many years, but it's the project team, yes.

Q Above that, you will see that there is the "Project Board". Were you involved with the project board?

A I was, yes.

Q So, again, just so I can understand where the project director would sit, you were involved with the core project team. Is that effectively doing the day-to-day of the project?

A Yes, I am leading that project team and all the various activities and duties that they have, yeah.

Q Then you are also sitting on the project board. What's the project board doing?

A The project board is

there as a governance and assurance mechanism where issues that need to be escalated and discussed at a higher level are brought forward to the project board. It's constituted with a whole variety of, again, stakeholders within the board, and outside the board in this case. It was a progress monitoring vehicle as well in the sense of we got various reports from the various work streams as an update. Again, if that-- if there was anything of significance and interest, that would be escalated further to things like the F&R Committee and eventually the main board when it came to very, very strategic things such as appointment of, in this case, I presume a PSCP prior to my involvement, but certainly the special purpose vehicle that we eventually selected.

Q We will come on to that. So we have got the core project team doing the day-to-day work, they would then report into the project board. You said that there were people internal to NHS Lothian and then also people external to NHS Lothian.

A Yeah.

Q So what individuals or organisations external to NHS Lothian would be involved in the project board?

A We had representatives

from the immediate health boards, so Fife, Dumfries and Galloway, we also had people from the University of Edinburgh because there was a university component in the projects, we had people from the Scottish Government Health Directorate, SFT were part of the board, and then the rest I think were generally internal to Lothian.

Q You mentioned “SFT”. Is that Scottish Futures Trust?

A Correct, yes.

Q In terms of the Scottish Futures Trust being involved with the project board, is an individual from Scottish Futures Trust sitting in on the board in a decision-making capacity or are they there in an advisory capacity?

A I always saw them as an advisor. I think they used the phrase, “We're here as your critical friend,” seemed to be used a lot. So they presumably made decisions in their own right in terms of the programme of works, but I don’t think they were a decision maker as such on the board.

Q But when there is a meeting of the project board, there’s an individual from Scottish Futures Trust who attends those board meetings?

A Yes.

Q Again, just thinking of

how things might be escalated if the project board wants to escalate it, you mentioned a committee that you referred to as the "FFR".

A F&R, Finance and Resources.

Q What is the F&R?

A They're principally there to keep the finger on the pulse with financial arrangements and the costs of projects, the expenditure that the board has in terms of revenue and capital-funded projects.

Q So you used an acronym. What does the acronym stand for?

A Finance and Resources Committee.

Q Finance and Resources Committee. So matters presumably of a financial nature are escalated from project board to that committee?

A Yes.

Q You mentioned then NHS Lothian Board itself. I think you used the term that it would be "strategic decisions" that they would be making in the project.

A Yes, I seem to recall attending quite a few main board meetings where it was-- where things were at a sufficient pitch, if you like, in terms of importance, so the appointment of the preferred bidder,

when we were contemplating litigation at a future date. So some very serious and significant issues would be escalated to the main board or the F&R Committee and an extraordinary F&R Committee would be set up.

Q Thank you. Now, in terms of the project team and what we will see below that, you mention within your statement that you led the NHS Lothian project team of 12 managers. Again, just at a very high level of generality, what types of individuals are then feeding in, in terms of these 12 managers, to you in your role as Project Director?

A Sure. It varied. Twelve is probably an average. Sometimes we had about 16 or more, but they came from a variety of parts of the health service. They were generally what's called placements into the project, so Capital Planning would supply project managers who were of a technical nature, we had people from a clinical nursing background. So it was a very good variety of people. We had people from estates and facilities who, again, had a technical background and other people that came through the service in terms of operational management, strategic planning, as well call it, background. So it was a very good mix of, as I said

before, complementary skills.

Q So you mentioned Capital Planning as one example. What would the capital planning team be doing in the project?

A They were principally involved in interpreting the clinical requirements and translating that into schedules of accommodation and into a technical form. That was really their big impetus. Also, in terms-- linked to that, equipment scheduling as well, which is, as you can imagine, a huge component in an acute healthcare facility.

Q We will come on to talk about external advisors in a moment, but the Inquiry has heard evidence that NHS Lothian had appointed external advisors both when the project's capital-funded and when it's revenue-funded. In terms of those external advisors, how would they link in with either the core project team or to the project board? How did those linkages take place?

A It was slightly different in both-- The project sits in two phases, as you're well aware. So the capital-funded project, there were professional services contracts with a company that supplied a cross-consultancy project management service and a planning supervisor, as it was called, in an

NEC3 contract. They also would, not particularly on this project, but they can in other projects – the ones I'm doing at the moment, for example – they have the ability to subcontract to technical people like architects, engineers, etc. Of course, that didn't apply on this project when it was capital funding because we had a Principal Supply Chain Partner on board and they had their own supply chain of designers. When it became NPD, similarly, we had to expand that advisory base, if you like, far beyond technical, which we certainly needed to have, but we had to employ legal advice and finance advice on NPD.

Q Now, we'll come on to explore the term I am going to use in a moment in greater detail, but one of the terms that the Inquiry has heard so far from other witnesses is the "reference design team" at certain points.

A Yeah.

Q In terms of the structure that we are looking at, how would that reference design team link in to the core project team and/or the project board?

A Yeah, that was a unique vehicle again, because of the nature of NPD and the challenges that we were facing at the time, to communicate to

bidders what we had as mandatory requirements, principally operational functionality, to do that with-- Also, the whole premise of NPD is to transfer sufficient risk to the private sector that then satisfy European accounting rules, and the Scottish Government can then cope with the project or log the project off balance sheet. So it was all about transfer of risk. So we were trying to see-- trying to devise a vehicle that enabled us to communicate, in an illustrative way, operational requirements, which are about adjacencies of rooms to rooms within departments, departments to departments within the building. Also, on the basis of, and I think you've heard from other witnesses, two supplemental agreements that we had to agree with Consort Healthcare to, first of all, release the land and also get rights of access and oversail rights for cranes and all sorts of things and services. In doing that, we were obliged to adhere to very, very specific requirements, for instance, the public utilities coming into the site was down through a very specific corridor, which we had no latitude on. So that became a compulsory requirement for bidders because we had (inaudible).

Q We will come onto all of that, but if we stand back from the detail, just at a level of generality, there's this body called the "Reference Design Team", they want to have input to NHS Lothian. What is the linkage between the reference design team and the organigram that we are looking at?

A So the reference design team were ring-fenced-- Sorry, I might need to explain this, I think, because it is important. They were ring-fenced from the other work streams developing what became the Invitation to Participate in Dialogue information, so the board's construction requirements being a principal part of it. They were ring-fenced because we were keen that the designers that were employed through our project managers to do the reference design were not precluded from bidding at a future date. Scottish Futures Trust were not initially too keen on that. They thought they should be not allowed to bid. There's a very limited pool of these people and we felt that would be restrictive. So, taking legal advice and contracts advice, what we did was we ring-fenced that reference design team in the sense that there were people from the project team, so the clinical director at the time and a couple of project managers, along with the project managers externally,

managed that reference design team. I think, to answer your original question, the output from that developing reference design was fed into the project board through myself and the clinical project director.

Q Was anyone from Capital Planning involved in that linkage?

A Very much so. One project manager, particularly from memory, was Capital Planning and the other was from a clinical nursing background.

Q Can you remember the names of those individuals?

A Neil McLennan and Fiona Halcrow, I think, and certainly Janice MacKenzie was the clinical director.

Q Did Mr Iain Graham have any involvement in that linkage between reference design and NHS Lothian?

A Not so much, no. Iain was very busy on other things. Iain's role developed in the project to very much looking at the legal side of it.

Q Now, I think you were telling the Inquiry about some of the site constraints that the project had. Again, just so that you are referenced within your statement, I am really looking at paragraph 6 of your statement onwards. At that point, you

mention that there comes a point within the project whereby there's an existing private finance initiative at the site in Little France, and there is then going to be potentially another revenue-funded hospital that's coming on to the same site. You outline that you consider that there are quite a lot of challenges associated with that. What were some of the challenges that you faced as project director?

A When it became-- When the project came to an abrupt halt in the capital funding and it became NPD, as it transpired, I think there was four kind of areas that we-- questions that we asked ourselves, really. The first one was, well, what is the scope of the project now, where was it, when was it expected and how were we all going to get there? So, if we just take the first three first because they're quite simple, really: the "what" was now a combination of the Children's Hospital and the Neurosciences Hospital, so we knew our scope, the "where" was the Royal Infirmary – nobody was saying it was the wrong site, it had gone through an options appraisal many years ago – and the "when" was very clear that it was ASAP. The how bit was the difficult bit and it was the challenge all the way through. How we did it was, just as

we're saying here, we had to bring in a commercial organisation that is significantly risk-averse facing another commercial organisation with the same approach. We looked at were there precedents for this in the UK or anywhere actually in the world. I think we found one educational establishment in England somewhere that had a PFI on a PFI. Most of the time, these PFI sites, they're extended by the original PFI operator, but this was quite a unique occurrence and we knew that this would be challenging. The challenges were, just as I said, about risk and who took risk for certain things. From a practical point of view, it was the ability that the new hospital was as autonomous as possible so it stood on its own feet from a services point of view, so one PFI operator was not dependent on another PFI operator and vice versa. So trying to make it as clean as possible, trying to reduce the number of physical connections, for obvious reasons, as well, and then the operational requirements with two PFI operators adjoining one another in terms of the campus.

Q Because, again, within your statement at paragraph 20, for example, you make the point to say that healthcare projects are always complicated and major and high value

projects have significant complexities. But, in terms of the additional complexities, in terms of putting a revenue-funded project within a revenue-funded project, were there any real specifics to that beyond what you've already explained?

A I think the biggest difference was the imposition of the finance and legal requirements that NPD brought. I mean, we had always had the technical challenges for sure, but I think it was the additional load of the labyrinth of lawyers and financiers that were involved all the way through.

Q How time consuming was all of that for the project team to work through?

A It took a lot longer to get to probably where we wanted to be than we would have done. It would've always been difficult with the PFI operator to get the supplemental agreements that were so essential, but I think it just added complexity and time for sure.

Q Again, just one of the terms of reference that the Inquiry requires to grapple with is whether ultimately the site was appropriate for the hospital. Certainly, I had you noted as saying that despite all the difficulties, complexities and challenges that you talked about in

your evidence and in your statement, you said that no one thought it was the wrong site.

A Absolutely.

Q Why do you say that?

A Well, the option appraisal had been done before I started with NHS Lothian, but it was very apparent to me, listening to colleagues and looking at the clinical justifications, that bringing paediatric services and neurosciences to an already acute hospital with the benefits of sharing emergency facilities, sharing critical care facilities, etc., particularly the synergy with neurosciences and the University of Edinburgh, who run the campus as a teaching hospital, it all made absolute sense to me, as a non-clinician I have to say, but just as a layperson. So I was never other than convinced that it was the right site.

Q Thank you. Now, within your statement from paragraph 7 to 15, you address two supplemental agreements, Supplemental Agreement 6 and Supplemental Agreement 7. Am I right in thinking that Supplemental Agreement 6 was effectively aimed at securing the land that formed Car Park B where the new hospital was ultimately constructed?

A Correct, yeah.

Q Again, just in your role as

project manager, what, if anything, were you doing in relation to Supplemental Agreement 6?

A Well, I was part of the team that were negotiating with Consort Healthcare. I was feeding in the practical needs of the project. So, in terms of the access to the site, as I mentioned earlier, the services, there was quite a big deal made of oversailing of cranes, etc., and how would they affect the Royal Infirmary. So, where there were construction issues and development issues of that nature, I would feed in to the legal and financial team.

Q Then, again, you explain that Supplemental Agreement 7 is really aimed at what you describe as "various enabling works". Could you just explain, again, for lay individuals what do you mean by "enabling works"?

A Well, almost any construction site, any development site is not, unless it is deliberately designed that way, is not ready to take a building. It needs enabled. This was certainly the case here because Car Park B was a car park and had never been designed as anything else. So there were major utilities running through the site. There were two sewers, actually. We had to divert one

of the sewers, the twin trunk sewer, to the south. We had to reroute Consort's private gas pipe. There was fibre optic cables from the university running everywhere. So there was a lot of services lifting and shifting, as it's called. There was also the need to bring the flood prevention facilities at the campus up to modern standards, whether it's to do with climate change or not, the world has moved on in the 20, 30 years since it was designed, and there's now a much more onerous flood defence requirement as part of planning consent, so there was flood prevention works.

The other major change was the existing bus network serving the Royal Infirmary, the loop road that came in with bus stances – we had to sever that basically to get a physical connection to the Royal Infirmary which meant rerouting the buses to the east of the hospital, getting a new bus hub to the east. The other thing that was very important was to create-- or Consort, to create-- I should say that Consort initiated and actually delivered all these works for us. The other thing was to create-- some people referred to it as a-- I think I coined the phrase a "docking station". So, rather than the new PFI operator coming in and physically attacking, if you like, the

Royal Infirmary, we would get the Royal Infirmary PFI operator to create a plug-and-play type facility so they could connect with little difficulty into the Royal. So that was work at the emergency department. It meant partial demolitions and the creation of the stop or nib coming out of the Royal.

Q So again, if we boil down Settlement Agreement 7, we're talking about flood prevention work, services, essential infrastructure, and then making sure that there can be the physical link between one hospital, which is revenue funded with a particular special purpose vehicle, linking into another hospital that's going to have a separate special purpose vehicle.

A Correct, yeah.

Q Now, in terms of Settlement Agreement 6, which is securing the land, and Settlement Agreement 7, which is the enabling works, you've talked about the additional complexities because of the revenue-funded project, within the revenue-funded project, but if we stand back from that, regardless of whether the project is capital funded or revenue funded, would you still have had to have gone through an equivalent of Settlement Agreement 6 and

Settlement Agreement 7?

A Oh, yes, absolutely.

Q Because, again, in basic terms, you need the land to build the hospital and you need the services and infrastructure before you can do so?

A Yeah, yeah.

Q Thank you. If I could ask you to have in front of you, please, the outline business case for the project from 2008. So that's in bundle 3, volume 1, at page 272.

THE CHAIR: Thank you. I wonder if we could just keep the level of questioning and answering just a little further up, Mr Currie, so that everyone can hear. I'm particularly sensitive on that, but I don't think that I'm the only one, and we've got to bear in mind the YouTube feed. So, question and answers, maybe just a little louder.

MR MACGREGOR: Certainly, my Lord. So, Mr Curry, I was asking you to look to the outline business case from 2008, which begins at bundle 3, volume 1, at page 272. Do you see that?

A Yes.

Q Now, whenever you came into the project in 2009, this document would already have been created and approved. Did you review the document?

A I don't think I would have reviewed it in its entirety. I certainly used it as a reference document, I'm sure, to bring me up to speed with the project, yeah.

Q Because is if we look, for example, to page 376, you see that within that document there's a procurement strategy that's set out.

A Yes.

Q So would that have informed you, for example, of how NHS Lothian intended to go about the procurement exercise when it's a capital project?

A It would, yeah.

Q If we look, for example, on to page 380, paragraph 16.2.14, do you see that?

A I do.

Q Which states:

> "It is proposed that the Reprovision of the new C&YP's hospital adopts the Framework Scotland agreements that should be in place by the fourth quarter of 2008 enabling NHSL to minimise the public procurement period and bring design and contractors on board earlier to achieve cost certainty."

Do you see that?

A I do.

Q So was that your understanding of what NHS Lothian wanted to achieve?

A Yeah, that's the essence of the framework in that boards can call down from a framework-- they wouldn't have many competition, though, contractors with a-- not just a building contractor, but a building contractor with a supply chain, and utilise them quicker than going to the open market with competitive tendering.

Q Again, as is stated there, if you do that for all the reasons that you've given, you can minimise the amount of time that you need to spend on the procurement exercise.

A Yes.

Q It continues, just returning:

> "NHSL will maximise the pre-design preparation period to progress masterplanning to secure outline planning consent in relation to the Little France site thereby mitigating any initial period slippage though a focused use of current internal and external resources and available client input."

Do you see that?

A I do.

Q What was your understanding of that terminology?

A This is the capital-funded days and it looks like that's suggesting that there may be the need – although I don't think it's-- from memory, it didn't happen, where, contrary to what happened on the NPD side, where we did go for an outline planning consent, or planning application principle it's now called, which would pave the way for a detailed application by the framework contractor in this case. I can't, from memory-- I don't think we did get a planning in principle – I may be wrong – for the capital funding scheme.

Q Thank you. If I can ask you to look on, please, to page 382 and to paragraph 16.4.1.

A Page 382, paragraph 16.4.1. Do you see a paragraph beginning "The new build hospital…"?

A I do.

Q So it states that:

> "The new build hospital will follow the design aspirations and guidance laid out in the Policy on Design Quality for NHS Scotland (2006) to which NHSL subscribes and implements through its Design Champions. The design brief will address these requirements and also the specification and site constraints

outlined in section 16.8."

Do you see that?

A I do.

Q Now, obviously, as I understand it, you hadn't previously worked within the NHS; you'd worked in the construction industry, but you've just come in to work within the NHS environment. Is that correct?

A Yeah, I spent two years with a major architectural healthcare practice in the UK, so I wasn't unfamiliar with healthcare.

Q What did you understand the Policy on Design Quality for NHS Scotland (2006)-- What was that?

A I think it was an ambition initiative to bring the quality of healthcare buildings up in standard in terms of architectural quality. I was aware that there was subsequent amendments to that as well, I think-- was it "Vision for Health" I think it was called, or something at that time? So it was it was an impetus to try and bring healthcare buildings up to a much better quality environment.

Q So, in terms of when you came into the project, you've seen that this has been approved by the board, approved by Scottish Government. The build has to be in compliance with the Policy on Design Quality for NHS Scotland (2006) at this point.

A Yes.

Q So would you, in your role as project director, have had to consider that policy?

A I'm sure I did at the time. I certainly was aware of it. I can't remember the detail, I'm sorry.

Q It's just I think all I really want to ascertain is, within NHS Lothian, whose responsibility would it be to make sure that any design for the hospital complied with that policy?

A Well, from memory, I think the design champions had been appointed long before I joined. There was a design champion at board executive level, and then one at technical level. Obviously, in my role as project director, I would be heavily involved in design, yeah.

Q So, again, just so I understand this, your understanding would be that the policy would be understood at-- someone at a board level, and I think you mentioned someone at a technical level.

A Yeah.

Q Again, thinking back to that organigram, where would board-level individual-- would sit? Where would the technical person sit?

A I think the technical level would be the director of capital planning and his role of sitting the

project board and overseeing that as an assurance type role.

Q At that time, would that have been Iain Graham?

A That would be Iain, yes.

Q Thank you. If I can ask you to look to the 2006 design policy; so if we could look to bundle 3, please, volume 1, at page 113. So that's bundle 3, volume 1, at page 113. The first page should simply say: "A POLICY ON DESIGN QUALITY FOR NHS SCOTLAND". If we look on to the next page, you'll see in the top right-hand corner there's a date of 23 October 2006. Do you see that?

A I do.

Q It's a document headed up: "A POLICY ON DESIGN QUALITY FOR NHS SCOTLAND". Does this ring any bells? Have you seen this document before?

A Not recently. It's vague bells I think would be ringing.

Q No, that's fine. In fairness, we'll look at the document, and again, if you simply can't remember the detail or you haven't seen the document, please do let me know. So it begins in the summary stating:

> "This letter provides colleagues with a statement of the Department's Policy on Design Quality for NHS Scotland (Annex A)."

So, effectively, this is being provided to chief executives of NHS boards, as you see in the "for action" sign on the right-hand side, but really the policy that it's providing begins from page 117 onwards. So, on page 117, you'll see a document called: "A Policy on Design Quality for NHS Scotland" from 2006. Do you see that?

A I do.

Q Again, does this ring any bells whatsoever with you?

A It does in the sense of-- I seem to recall an initiative called "Vision for Health", but I may have got the wrong label, and it was something that the Scottish Health Directorate were starting to push, yeah, through the use of A&DS, Architecture & Design Scotland.

Q Yes. Thank you. If we could look on within this policy to page 125, please.

A I have it here, yeah.

Q You'll see that, on the top, it's called "Mandatory Requirements". If I could ask you to look to paragraph 5, so Mandatory Requirement 5 beginning, "All NHS Scotland bodies…" That's page 125, paragraph 5. Do you see that?

A I do.

Q So it states:

"All NHS Scotland Bodies engaged in the procurement of both new-build and refurbishment of healthcare buildings must use and properly utilise the English Department of Health's Activity DataBase (ADB) as an appropriate tool for briefing, design and commissioning. If deemed inappropriate for a particular project and an alternative tool or approach is used, the responsibility is placed upon the NHS Scotland Body to demonstrate that the alternative is of equal quality and value in its application."

You see that?

A I do.

Q So when you came into the project, was it your understanding that the Activity DataBase was going to be used as the tool for design?

A Absolutely, it's an industry standard. That is one proprietary software package of two, I think, mainly in the UK. Every architectural practice and healthcare in the land uses that or Codebook I think is the other one. Whether it's mandatory or not, it is the basic building block of developing the very detailed specifications needed for rooms within a healthcare establishment. So it is, yeah, absolutely essential – an integral part of the design process.

Q Thank you. If we could look on to page 133, please. So the full paragraph just above "The Client Designer Adviser", so it's a paragraph beginning: "Spaces designed using ADB…" At page 133, do you see that paragraph?

A Yeah.

Q Thank you. It states:

"Spaces designed using ADB data automatically comply with English planning guidance (such as Health Building Notes (HBNs) and Health Technical memoranda (HTMs) as ADB forms an integral part of the English guidance publication process. Whilst Scottish users can create their own project-specific briefs and designs using ADB's extensive library of integrated graphics and text which includes room data sheets, room layouts and departmental room schedules, extreme care should be taken to ensure that such data generated by the package are consistent and compliant with Scottish-specific

guidance such as Scottish Health Planning Notes, Scottish Hospital Planning Notes (SHPNs) and Scottish Health Technical Memoranda (SHTMs) as published by Health Facilities Scotland."

Do you see that?

A I do.

Q Again, was that your understanding of what NHS Lothian should be doing in terms of the design for the hospital?

A Yeah, I would add to that as well. The ADB sheets are-- The ADB library, the database isn't-- can at times be a bit cumbersome and does not, on all occasions, deal with specific clinical finetuning of the use of spaces and rooms. So one board or one set of clinicians might have a slightly different way of operating in an area. That would mean that the ADB, the equipment scheduling, and the provisions in it have to be modified in a bespoke way for rooms.

Q You use the term ADB sheets. Other witnesses have used the term room datasheets.

A Yeah.

Q Are you really saying that your understanding was that room datasheets were going to be created from the Activity DataBase?

A Yeah, I like to use the phrase "room datasheets" because that is the output from the process, given that the ADB is one building block – it's a very central building block for it, but it's then modified by the users, by the board, and by whatever the specific circumstances to that room-- space that we're talking about. So the ADB is part of the process to arrive at a room datasheet.

Q So ADB is effectively the computer package that allows you to create a physical room datasheet.

A Yes, it's a proprietary software package that you subscribe to, yeah.

Q Again, your understanding as set out in the policy here is, if you use the ADB package, it's going to comply with English guidance such as Health Technical Memoranda; but you've said, in your experience, both in the private sector and when you come into the NHS, is that you would still have to specifically check that it complies with any specific guidance such as Scottish Health Technical Memoranda.

A Yes, and the unique arrangements of the of the rooms and the clients' desires and requirements.

Q So, again, just so I can be clear about the intention – and,

again, I'm talking at this stage about the intention of NHS Lothian – when you come into the project, is it the intention of NHS Lothian that the design for the hospital will fully comply with the guidance set out here, including Scottish Health Technical Memorandum?

A Yes.

Q Again, just so I'm absolutely clear, what would your position be in terms of within the project, that organigram we look at, whose responsibility is it ultimately to ensure that there is compliance with Scottish Health Technical Memoranda?

A In which part of the project, capital funded or NPD?

Q At this stage we're talking about capital funding.

A Well, it's a-- the NEC3 contract, which is the one that was used – it'd be 3 anyway at that stage – that is a process of collaboration, certainly between the client and the builder. So the client, in our case the health board, prefers what's called employer's requirements. They set out the clinical requirements, particularly for each room. So we would prepare clinical output specifications; they would refer to SHTMs, etc., etc. relevant at the time. The builder then

takes that and he provides-- he plays back to us what's called contractor's proposals. You then work collaboratively with the builder to get to a package of information called "works information" in the contract. That works information then is delivered by the builder and, unless there are caveats or derogations in it to the contrary, the responsibility is for the builder to provide a facility in compliance with the works information. The works information would refer to any Health Technical Memoranda.

Q So, again, just to be clear, your understanding would be, in a design and build contract, that that risk of noncompliance would sit with the contractor.

A Unless it's derogated from in the works information package, yeah.

Q In terms of internally at NHS Lothian, you use the term "we" a few times whenever you're saying "we". The Inquiry has heard evidence from both Mrs Sansbury and Mrs Goldsmith who sat on the board of NHS Lothian, and both their evidence was to the effect that, in terms of technical guidance such as Scottish Health Technical Memorandums, that's not something that they would be considering at board level. So, in

terms of ensuring that compliance, where within the organisation does responsibility sit?

A It's really the project team and any advisors and consultants that they would use. Where we would have a specific query on an issue, we would always refer to HFS as the national body of expertise.

Q So am I right in thinking when you're talking about levels, are we talking about the project board or are we talking specifically about you in your role as project director?

A I would say it'll lay with the project team and myself as project director, yeah.

Q Now, you mentioned HFS, Health Facilities Scotland 2006, we're looking at the 2006 policy – what role, if any, did Health Facilities Scotland have in ensuring compliance with technical guidance?

A I think the role stayed pretty constant all the way through the project and through its different phases in the sense that, where we had a specific query or we wanted advice, be it on infection control, be it on high-voltage cables-- I seem to remember, ventilation, water, we would go to HFS and seek guidance and advice. So it was an advisory role.

Q Thank you. I still want to

stay within the capital funded stage, that's the period up to 10 November 2010, as you tell us in your statement. Am I right in thinking it's on that day, on 10 November 2010, that NHS Lothian becomes aware that the project is no longer going to have capital funding?

A Aye, that does ring a bell, yes.

Q Did NHS Lothian have any advanced warning from Scottish Government that that was going to take place?

A Not to my knowledge, no, the project team certainly didn't.

Q So, at this point, you'd mentioned that a company called BAM had been appointed as-- I think you referred to it as principal supply chain partner. What's happened in the project up to this point? BAM are in place, but what's happened? What's been agreed at this point?

A We really took the project to a stage where it was ready for the planning application, a detailed planning application to be made. We had worked on the detail design to get to that stage sufficient enough that BAM could start to then go and actually get subcontractor's interest and subcontractor's prices. In other words, working to what's called an

NEC option C I think it was, target price. So the design was pretty well developed. We were about to make a planning application. We were in discussions with Consort on the basis of what became SA6 that we spoke about earlier. They were taking a bit more time, I seem to recall, and we were slipping in programme at that stage. I think I did report to the programme board around about that time that we were slipping because of that. So the project was pretty well developed for a children's only hospital.

Q Now, the Inquiry's heard evidence that the planned contract was going to be an NEC3 standard form contract. Can you just explain what's your understanding of an NEC3 standard form contract?

A Yeah. It's a new engineering contract; it's one that's used extensively by public sector organisations, and private sector. I described it, I think, a bit earlier in terms of employer's requirements, contractor's proposal, works information. It tries to ensure that both parties are open and transparent in terms of issues, in terms of progress, trying to flag up as early as possible risks or potential difficulties coming. It's very management hungry, certainly

on the contracting side. It needs a lot of management input. It is very programme driven. Programmes are produced by the shedload at every stage in the project; they are used for evaluation and payment purposes. So it is quite an intensive process. It can work very successfully, though. I've worked on projects where it's been very successful.

Q In terms of that contract, the NEC3 contract, where would design risk sit? Does it sit with the client or the contractor?

A I think, as I said earlier, it sits, in my estimation, with the contractor in terms of the agreed works information.

Q You mentioned in your evidence that you consider that the design was at quite an advanced stage. Is that correct?

A Yeah, it was-- It couldn't have been built at that stage, but it was at a stage where we made a planning application, so it was certainly at detailed design stage and getting into the real nitty gritty of subcontract packages.

Q So, in terms of engineering specifications, such as technical specifications for a ventilation system, have they been created at this stage or does that come later?

A They would be-- They'd be starting to be looked at in detail by BAM and their engineers, yeah.

Q Do you know if BAM had produced room datasheets at this stage?

A I would suspect they would be working on them. I can't recall the detail.

Q Again, I appreciate it's a long time ago, and it might be more about what your understanding was, we're not talking about necessarily specific designs, but what was your understanding in terms of whether BAM would be preparing room datasheets for the project?

A Oh, they would absolutely be, yes.

Q Now, in terms of the NEC3 contract, that's whenever it's the capital project. There's then the change to the revenue-funded model. Could the standard form NEC3 contract simply have been used for the revenue-funded model?

A No. I seem to recall many conversations with colleagues and SFT and others that the senior debt providers, the funders, the financiers, would want to ensure that all the risk sits squarely with the contractor, with the builder; and a lump sum price with the contractor taking

the risk would be where they would want to go. NEC3 is a bit more open-ended in terms of the final price. So that wouldn't have held muster with the financing.

Q So, in terms of the contract structures, whenever the funding model changes, the contractual structures have to change as well as----

A Fundamentally, yes.

Q Now, I'd like to ask you some questions about the period now when there's the switch to the revenue-funded project. Could you just explain what impact that had on the project? You've told the Inquiry about the stage that NHS Lothian had got to work with BAM, but what impact does that then have on the project when the funding model changes?

A It was taking stock, I think, as I mentioned earlier, about where we were and where we needed to go and how we got there. As I said – I think I said earlier, I've forgotten now – that one of the fundamental bases of NPD is risk transfer to the private sector to achieve certain accounting rule targets or requirements. As part of that risk transfer, design risk needs to transfer in its entirety with the exception of something that we called operational

functionality, which was a development of clinical functionality; it was operational functionality because it included some of our facilities management requirements, so they are essential and mandatory requirements. So it was a-- "How did we communicate all this to the bidders?" was the first task, and, "What resources did we need to do that?" given that we had to basically totally stop what we were doing. BAM didn't continue. We had to then see it from a technical angle, how we could secure advisory services, and also bringing in – as I said earlier, I think – financial and legal, and also to be clear on the scope, which I mentioned earlier, and just check that it was the same location, etc., etc.

Q If I can ask you just to have your statement in front of you and if we could look together at paragraph 19, please. So paragraph 19, the second full sentence beginning, "We had to prepare a revised business case".

A Top of page 208, is it?

Q It is the bottom of page 207 on my copy beginning, "We had to prepare a revised business case". Do you see that?

A Yes, got that.

Q So it says:

"We had to prepare a revised business case, prepare for a new procurement model and consider how best to utilise the design work already done. This involved liaising with internal and external stakeholders and independent advisors."

So you talk about the "internal and external stakeholders". What do you mean by that?

A I think it was principally the clinical teams who had been through, you know, certainly in my-- longer-- a year and a half for me, but longer in terms of the project before I arrived – getting to a stage where they articulated and documented their clinical requirements. So it was how we kept them on side, if you like, taking the project forward, given they're all very, very busy people and time is short. So we had to do a lot of internal discussion with the clinical stakeholders principally, I seem to recall.

Q In terms of the independent advisors, who was it you were engaging with at this point?

A Well, we eventually-- I can't remember when they came on board. As soon as possible, I think, was the need, but-- So we had EY as our financial advisors and MacRoberts

as our legal advisors, and Mott MacDonald were our technical advisors, so we would've been talking to them as soon as we could get access to them.

Q So you say Mott McDonald are the technical advisors. What role do they have at this point in the project?

A Well, they were brought in because we needed to get somebody who could demonstrate experience, and as recent experience as possible, of major acute healthcare PFI experience, and we had to do that as quickly as possible whilst complying with procurement rules. We set upon OGC Buying Solutions, I think, as a framework, a national framework. Mott MacDonald were on that framework so we could call off-- and they were at pre-agreed rates, etc., a commercial detail. So they had also demonstrated that, and particularly one individual who I think you're seeing on Friday, Mr Cantlay, had direct experience of Forth Valley PFI, and they demonstrated that they could bring that very recent knowledge to PFI, NPD as it was now. So we selected Mott MacDonald on that basis.

Q You describe bringing Mott MacDonald in because of their acute healthcare PFI experience. Just

at a slightly more granular level of detail, what were they going to be doing? What were they going to be giving you advice on?

A There's basically three arms to it, I suppose: technical advisors in the sense of bringing their technical expertise and how to shape and produce the documentation needed for us to communicate our requirements, so the BCRs, as I recall – Board's Construction Requirements – the process of engaging with the bidders we hoped to have, which was very elaborate and detailed, they also brought facilities management experience in terms-- to that and how to bring-- how to run a hospital of that size, and they also brought project management support as well, which was very welcome in terms of bolstering the internal team.

Q In terms of the skill set that you have talked about Mott MacDonald bringing to the project, did those types of skills exist internally within NHS Lothian for this type of revenue-funded project?

A Not in that level of detail. The one advantage of having an organisation like Mott MacDonald is that they have a huge range of specialisms from helicopter engineers to acousticians to fire engineers. This

project had just about every design discipline that you could imagine at some point in it. So we would not have anywhere near that level of expertise-- I don't think any health board will have that level of experience.

Q Again, I think I picked you up as saying that you had obtained Mott MacDonald's services through a framework agreement, is that correct?

A Yes. A national government framework arrangement, yeah.

Q In terms of the shift from capital to revenue funding, what role, if any, did Scottish Futures Trust play at that point?

A Scottish Futures Trust were there to give advice and guidance. They were principally concerned with affordability and the programme and sufficient transfer risk, as I said earlier. As I said many times, they said, "We're here as your critical friend, Brian." So they were very supportive, we had a lot of dialogue with them. They had views that we didn't share at times but we came to a very amicable understanding and direction. I think I mentioned one of them before about the reference design team. I seem to remember

quite a bit of dialogue about just what the reference design should show. They were getting slightly anxious that we were starting to define too clearly for-- or be too prescriptive for bidders. Curvy walls, I think, came up many times, and we eventually made it-- well, hoped, and I'm sure we did make it quite clear to the bidders that these were indicative requirements only and that you didn't necessarily need to do curvy walls unless you wanted to do curvy walls. So there was a lot of dialogue with them and a lot of close cooperation with them-- with SFT.

Q In terms of their role, are they providing that critical friend assistance simply on the financial side of the project or is it a wider remit?

A I think, from memory, it was very much about the affordability, as I said, so about the finance side of it. They were heavily involved in the financial close. I think SFT were the last person to give the nod to the swap rate, as I seem to-- It was called at 25 minutes past three on a Friday afternoon with Brussels on the phone. So it was very much the finance side of it and the general-- how it fitted into their programme of NPD.

Q I want to turn now and ask you some questions about the reference design that you mention in

your statement from paragraph 22 onwards. Again, I just want to stress what the Inquiry is considering at this diet in the May hearings. The Inquiry is interested in general issues, in particular the decision to utilise a reference design approach, but the specific development of the design, the granular detail, that's going to come at a later stage of the Inquiry. So, if we could just begin at a very basic level, what is your understanding of a "reference design"? What does that term mean?

A Well, we arrived at a reference design-- It could have been called many things. Diagram probably might have been more useful now in hindsight, but the reference design essentially built on what was more commonly known as an exemplar design in PFIs where the client prepares a design that illustrates in conceptual terms a possible solution in architectural engineering at a very high-level concept. But because we had the need to communicate to bidders not just a mandatory requirement on operational functionality that I mentioned earlier, but the very clear and distinct obligations that we had from Consort Healthcare in terms of Supplemental Agreement 6, we decided we needed

to illustrate that again for the bidders. So we called it reference design rather than exemplar because it was a bit more prescriptive than an exemplar design would have been. It was a very useful tool in the sense of communicating to the bidders, but also communicating internally.

It also-- The operational functionality bit is really important because that's the bit we salvaged, if you like, from the capital-funded scheme. All the good work that had been done by the clinical teams with BAM and with ourselves, we didn't use BAM design, but what we did was we stripped back to the clinical pathways and the clinical adjacencies and the concepts of rooms and spaces and adjacencies and used that to inform what became operational functionality as illustrated in the reference design. It also was very, very useful in terms of developing a cost plan internally, so the quantity surveyors could actually see some drawings. So, again, at high level, but it's easier for them if they see drawings than just narrative.

It was also used in the ongoing negotiations and then eventual success of achieving planning in principle on the City of Edinburgh Council. SFT were very keen on it, as we were, because it meant that

bidders would have a reduced risk in terms of abortive tendering costs because the time when we got to competitive dialogue would've been shorter than it would've been if we had given them an exemplar design which was not as prescriptive. So it meant saving in time later.

Q Just so I am understanding this, an exemplar design is a fairly generalised concept design as opposed to a reference design, which is more detailed in terms of the health board's requirements?

A Only more detailed in the sense that it conveyed the Supplemental Agreement Consort obligations that we had. Operational functionality, I think an exemplar design's-- is an exemplar design as well, but it would probably be a clinical functionality only. So we took it-- we involved FM in that as well. What it doesn't do, it doesn't go anywhere near the engineering parameters and compliance in that term. All that is contained within what were called the Board's Construction Requirements. So it's a diagram more than anything. I always saw it as a diagram, a schematic of an architectural realisation of operational functionality.

Q Now, you mentioned that there was a desire to retain design

work that had already been done by BAM when it was a capital-funded project. Can you just explain to the Inquiry, the point in 2010 where it's shifting to the revenue-funded model, what discussions are taking place internally in NHS Lothian about trying to retain that design work?

A Well, that was one of the first challenges was, "How do we keep the clinical teams on board, knowing that we hoped, and we did succeed in getting three bidders interested in the project?" So, as it transpired, three parallel workstreams of competitive dialogue, if we were starting from scratch again, literally from an exemplar design and going back, involving clinicians, they would have had three parallel rounds of meetings engaging with each clinical team, which would've been, I think, nigh near impossible. So we thought, "How can we use all the good work that we had done with BAM, utilise that and present that to the bidders as a starting point, i.e. the operational functionality side of it?"

Q Within NHS Lothian – again, thinking back to the organigram we looked at – who or which body made the decision that it should be a reference design that is utilised for the revenue-funded project?

A I recall it was very much a collective effort. SFT, for the reasons I said earlier, were keen, we were keen, there were various papers done, I seem to recall, as we developed our ideas with options, it was then approved at project board level. I would imagine it would probably even go higher than that, I can't recall, but it was a joint SFT-NHS Lothian consensus. Mott MacDonald as well were-- believed it was the right approach.

Q Okay. So, just so I'm understanding it, effectively, am I correct in saying you sat on the project board, so did the project board-- thought it was the right thing to do, presumably you, as project director, thought it was the right thing to do?

A I did, yes.

Q You mentioned that you were getting advice from Mott MacDonald. Again, not talking about the detail, but at generality, what are Mott MacDonald telling you about using a reference design approach?

A Well, I think they mapped out for us with SFT the advantages of it, the slight nuances that could be played on how to actually move a reference design into the competitive dialogue phase. So there were-- it was very much an advisory role.

Q Again, what I'm picking up from your evidence is that there wasn't really an alternative view. It doesn't sound like anyone was suggesting there should be anything other than a reference design.

A Yes, that was my understanding. It would have been-- We couldn't have contemplated, as I said, bringing the clinical teams through that journey from scratch again three times, as it transpired, over.

Q If I could ask you to have your statement in front of you again and, please, to look to paragraph 23, which in my copy is on page 209. So paragraph 23.

A Yes, I have it.

Q So paragraph 23, you state that:

> "Following a review meeting including Scottish Futures Trust (SFT), Scottish Government Health Directorate (SGHD) and MacRoberts LLP (NHS Lothian's legal advisors) on 23 December 2010, it was concluded that it would be beneficial to take a 'reference design' to the market."

Just obviously looking there, I appreciate it's a long time ago, but do you have any recollections of that meeting on 23 December 2010 and

what was being discussed?

A It was one of many meetings, and it was remarkable how quickly after 10 November it all happened. In other words, there was various discussions with those parties, as I just said, around reference design and the advantages in using it.

Q Again, you state, as you have told us in evidence, still at paragraph 23:

> "This was not just a case of taking BAM's design and re-badging it as a reference design."

A No. Absolutely not, no.

Q So, again, just at a high level of generality, how much work was required to take forward the design?

A In terms of from this stage onwards?

A From the BAM design to the reference design.

A It was basically taking the principles behind the design and adhering to that and using that as a basis to develop the reference design and our operational functionality. So very much work-- It became part of the reference design team's remit to do that.

Q If I could ask you to look on to paragraph 26 within your statement, please, you state at paragraph 26:

> "One of the key driving factors in adopting a reference design, which was set by everyone involved, was to salvage as much of the time, effort and cost that had already been incurred. It was the sensible thing to do. We did not want to throw out what had been hard-won clinical input, for examples discussions around clinical models and pathways. To repeat the process would eat into precious clinical time for the clinicians and medics."

Again, that is really consistent with what you have told the Inquiry today.

A Yes.

Q You continue, at paragraph 27, setting out the benefits as you saw them of a reference design approach. You say:

> "In summary, the benefits of a reference design were: (i) enhanced cost certainty at the outline business case …"

Why would it give enhanced cost certainty?

A Because I think, as I mentioned earlier, it would enable a cost plan to be developed, which would be more accurate than it

would've been if surveyors were just working off narrative and specifications. Once something's drawn in a diagram or a building form, it gives them an idea of all sorts of things to do with envelope cladding, etc., etc., so----

Q Then the second benefit, as you see it, you say:

> "… (ii) fundamentals of the clinical design were complete to the extent that there would be very limited future engagement of scarce clinical resource …"

A Yes.

Q So, again, just so I understand that correctly, I think you had mentioned earlier that it wasn't a complete design; what you're saying here that there would not have to be significant further clinical input. So just how developed is the design at this stage?

A It would have meant much less clinical input at the competitive dialogue stage. They wouldn't be going back to first principles and looking at, "Is that room the right adjacency to the other room or department?" So it was setting that as our operational functionality requirement. So there was a huge amount of work still to do, of course, but it meant the competitive dialogue process did not rewind back to a stage before that.

Q You say, "(iii) it would shorten the competitive dialogue phase". Why was that important?

A It was the need to get on and finish and deliver a children's hospital in Edinburgh. It'd been a long, protracted experience to date and everybody was keen to get it finished and get it delivered as soon as possible.

Q Then you say, "(iv) utilise available programme time," and then "(v) it would minimise abortive design cost and tendering risk for unsuccessful bidders," which, again, you have told us about in your evidence already. If I can ask you to please look at a document in bundle 3, volume 2, page 314. So bundle 3, volume 2 at page 314, which should be headed up in the top left-hand corner, "Lothian NHS Board, Finance & Performance Review Committee" ----

A I have it here, yes.

Q -- dated 12 January 2011. Now, we will see when we get to the bottom of the document that this was a document prepared by Mrs Goldsmith and Mrs Sansbury. Is this a document you have seen before?

A Yes. It does ring a bell, yeah.

Q So we see at 1.1 it sets out the purpose of the report:

> "The purpose of this report is to provide the Finance & Performance Review Committee with an overview of the progress made over recent weeks to review the Royal Hospital for Sick Children (RHSC) and Department of Clinical Neurosciences (DCN) reprovision projects, following the Scottish Government announcement on 17 November 2010 that these projects would be funded under the Non Profit Distributing (NPD) model."

Do you see that?

A Yes.

Q So, effectively, an update to the Finance Committee. We see the recommendations, that "The Committee is invited to," and then the second bullet point:

> "Approve progressing with a detailed reference design for a combined project as a key component of the NPD procurement route utilising either the current Framework Contract with BAM or by procuring the design team through the Office of Government Commerce …"

Do you see that?

A Yes.

Q Again, is that what you were talking about whenever you were saying that there was potentially going to be what you referred to as an OGC procurement?

A Yes. At that stage, we were examining whether BAM could continue and actually deliver this. Of course, in terms of procurement and contract law, that was not going to be-- it was never going to fly, so we quite quickly excluded that option.

Q Then we see at the fourth bullet point:

> "Approved the commencement of a tender process to appoint advisors (technical, legal and financial) …"

So is that what became, I think, EY, MacRoberts and then Mott MacDonald?

A Yes, yes.

Q If we go on to page 315, at paragraph 4, we see the background to the NPD, which I won't read out. If we could look on to page 318, please, and to section 6, "Procurement Options", we see at 6.1, it states:

> "We have an objective to minimise both the delay to the programme (also the Cabinet Secretary's aspiration) and the abortive and on-going costs;

ensure operational effectiveness going forward, and also to manage the overall site consistent with the aims of the BioQuarter development."

Do you see that?

A I do.

Q Now, there is reference to there being a desire to minimise delay to the programme and that also being the Cabinet Secretary or the Scottish Government's aspiration. Was that your understanding at this point in the project?

A Yes, yes.

Q Then at paragraph 6.2, the various procurement options are set out. Then on page 319, we see various procurement options being set out. Then at page 320, in paragraph 6.4, approximately four lines up from the bottom of that paragraph, do you see the wording beginning, "Although this decision"?

A Yes.

Q So 6.4, four lines up from the bottom:

"Although this decision requires to be made by NHS Lothian as the Statutory Authority it will be important that this is endorsed by SFT and SGHD."

Do you see that?

A I do.

Q So, again, was that your understanding as project director, that ultimately this is a decision to be taken by NHS Lothian, but that it would be hopefully endorsed by Scottish Futures Trust and the Scottish Government?

A Yes, it was, yeah.

Q Just for completeness, on page 322, you see, at section 10, Mrs Goldsmith and Mrs Sansbury say at 10.1:

"SGHD and SFT have confirmed their willingness to work with the Board's team on developing the business case requirements to minimise the programme but retain the appropriate governance."

Do you see that:

A I do.

Q In terms of your role as project director, do you recognise that statement? Did the Scottish Government and Scottish Futures Trust work with the board as the project moved forward?

A Oh, absolutely, yeah.

Q If I could ask you, please, to look within bundle 3, volume 2, to page 898. So bundle 3, volume 2, at page 898. Do you see a document called: "RHSC + DCN Approach to Reference Design… May 2012"?

A Yes, I do.

Q We see at the bottom that there's the Mott MacDonald name.

A Yeah.

Q Can you just explain, what was your understanding of this paper, the "Approach to Reference Design"?

A I think that must be getting to the stage where we were concluding the – as it says there – approach to reference design; so this would be getting to the actual mechanics of it, I think, at that stage, May 2012, I would have thought so. It basically sets out in detail the methodology of us using the reference design, the purpose of it, and how it would be used with the bid process default.

Q Again, as I've said, probably repeated, I don't want to get into the detail of the actual design at the minute, but is it fair to say that the board is having this paper prepared by Mott MacDonald, its external advisors, addressing the reference design as at May 2012?

A Yes.

Q If we could look on, within the executive summary, to page 905, please. Do you see a----

A I do.

Q -- section just above the bullet points beginning: "The key benefits are seen as being…"?

A Yes, I have it, yeah.

Q So the paper by Mott MacDonald states on page 905:

"The key benefits are seen as being:

Enhanced cost certainty at OBC

- Clinical Design largely complete – very limited Future engagement of scarce clinical resource
- Shortens Competitive Dialogue Phase
- Utilises available program time – parallel with Consort Negotiations i.e. no overall delay to strategic programme
- Minimises abortive design cost for unsuccessful bidders"

Do you see that?

A I do.

Q Again, is that consistent with your understanding of the benefits as set out in your statement?

A Yes, it is.

Q Then if we look on to page 907, paragraph 1.1, page 907, paragraph 1.1, we see the purpose of the report being set out:

"The purpose of the report

is to:

- Outline the reasons for preparing and the purpose of a Reference Design.
- Outline the level of detail required in a Reference Design
- Outline the distinctions between mandatory and non mandatory elements of the Reference Design
- Application of Reference Design during Competitive Dialogue
- Outline the development of the Reference Design"

So, in terms of that detail, that's what we would see if we read on within this paper.

A Yes.

Q If I can ask you to look on please to-- still within bundle 3, this time to volume 2 and to page 892. So bundle 3, volume 2, page 892. We'll see as we work through the document that this was a paper prepared by you on 8 May 2012. Can you just explain what the purpose of this paper was?

A It looks like it's a paper supporting and tabling basically the

Mott MacDonald document that you-- that we've just discussed, I would imagine----

Q If we see in the top left-hand corner, it's headed up: "Project Steering Board Meeting 11th May 2012". So, again, is this a paper that you're preparing to provide to that that board?

A Yes, the project steering board was the title of what became the project board; it was even called programme board at one time. So that's the project board that we've referred to earlier.

Q We see that the purpose of the report, para.1.1:

> "The purpose of this report is to recommend that the Project Steering Board confirms that the report 'RHSC + DCN – Approach to Reference Design dated March 2012'… is used as a basis for accurately conveying NHSL's… intentions to bidders…"

Do you see that?

A Yes.

Q Then if we look on to page 893 to paragraph 3, you'll see at paragraph 3.1:

> "The reference design has been concluded following the Project Steering Board's approval in July 2011 of the strategy for its

development given the benefits arising."

Do you see that?

A Yes.

Q So it seems that, at this point in time, that the decision has been made by what's called the project steering board, but you said that then becomes the project board-- that there's to be a reference design approach adopted for the revenue-based procurement.

A Yes, I think this report is really just a crossing the T's and dotting the I's in terms of how the reference design would be actually implemented, because we had been working on it for, well, a while before that.

Q If we look on it to page 895 just for completeness, we'll see that it's completed by Brian Currie, Project Director on 8 May 2012. Do you see that?

A I do.

Q The next document I'd like you to have in front of you, please, is in bundle 3, volume 2, at page 409. So bundle 3, volume 2, at page 409. So, is this a document called "NHS Lothian RHSC + DCN Little France – Procurement Options June 2011"? We see that this is-- the bottom left-hand corner, we've got Davis

Langdon, and in the bottom right-hand corner, Mott MacDonald.

A I do, yeah.

Q Can you just explain what your understanding of this paper was?

A I think that, without scrolling down, just reminding myself, I think this just sets out, again, some of the detailed arrangements for competitive dialogue, and the-- whether we should be moving with a number of bidders, assuming they were enticed to participate, and when we would go to maybe two bidders and-- rather than go with three or four right to the end; it'd be that sort of thing. I think I'll need to just look down to remind myself.

Q Certainly. So, if we look to the contents page on page 414, you'll see it says: "Introduction… Exemplar reference design approach… Identified options… Estimated costs for each option… Soft Market Testing…" and then "Agreed way forward".

A Yeah.

Q Is this input that's been provided by Mott MacDonald in relation to procurement options?

A Yes.

Q So if we look on to page 415, in the introduction section----

A Yeah, I do see it, yeah.

Q

"Since the combined RHSC & DCN project will now be procured under NPD, NHSL has been in discussions with the Scottish Futures Trust (SFT) to determine the shortest possible procurement route. The procurement process options, and their associated timescales, are directly linked to the approach adopted on the reference design and this paper considers three options around this along with their benefits and drawbacks."

Do you see that?

A I do.

Q Then if we look to the section headed up: "EXEMPLAR/ REFERENCE DESIGN APPROACH", second full paragraph just above the bullet points, it states:

"However, the intention here, based on discussions with SFT to date, is to go a step further and develop a 'reference' design and mandate certain elements as part of the ITPD. The purpose of doing so is to:

- reduce the overall NPD procurement timescales and associated bidding costs
- reduce the amount of clinical user consultation through the dialogue period
- provide greater cost certainty at Outline Business Case (OBC) stage
- provide greater certainty over the eventual design solution under NPD"

Do you see that?

A I do.

Q If I could ask you to look on to page 419, and to the penultimate paragraph beginning: "Each respondent...". So this is in the section 5, "Soft Market Testing".

A Yes.

Q It's the section of the report that outlines some soft market testing that had been conducted. In the penultimate paragraph, on page 419, it states:

"Each respondent was advised of the option A, B & C approach. The consensus was that bidders would prefer the design to be treated as an exemplar to enable them to have the freedom to truly innovate on

the project. Whilst option A gives some degree of flexibility, this was considered to be fairly limited."

So, in terms of the soft market testing, those in the market came back and said "We'd prefer an exemplar design".

A Yeah.

Q Why did NHS Lothian then go with a reference design?

A Because-- that's not a surprise. I think, on the contracting side, they would like more latitude. We were unable to give them that for the reasons I gave earlier. We had very set obligations to Consort through Supplemental Agreement 6 that we could not move from. So they had to be-- they were anchors, if you like, in design terms. So we were unable, essentially, to give the construction industry the degree of latitude that those four companies expressed a desire for.

Q If I could ask you to have in front of you, please, in bundle 7, page 687-- In fairness to you, Mr Currie, it might be helpful if we looked at paragraph 28 of your statement before looking at this document.

A Okay, I have it, thanks.

Q So we see at paragraph 28 of your statement, you state:

"The Project Team initially intended to complete the reference design within 12 months based on three rounds of consultation with clinical staff (Bundle 7; Document number 32; Page 687). The Project Board immediately sought to reduce this period to eight months with two rounds of clinical engagement. My recollection is that it was SFT (who sat on the Project Board) who were keen to shorten the programme of activities in relation to the reference design production, competitive dialogue and between preferred bidder and financial close, rather than NHS Lothian."

So, again, just so the Inquiry can understand it, it seems like there was a desire to really compress the period of the procurement exercise. Now, if competitive tendering is aimed at getting best value for the public sector, can you just explain why was it that the government exercise was to be constrained?

A I think it was the-- we mentioned earlier-- I mentioned earlier that the desire to bring the delivery of this project ahead and as quickly as possible. So SFT were looking at every opportunity to speed things up

essentially. We were having to balance that with our views on doing it in a way that would be adequate to provide the information that we needed. I certainly recall competitive dialogue programme meetings where SFT shaved quite a bit of months off the program. As it transpired, we had to extend dialogue by about the same period again. We introduced supplemental dialogue meetings at the time. So it was just that overall-- and not-- and quite understandable desire to bring the project on stream and deliver it as quickly as possible.

Q If we could then look to the document in bundle 7 at page 687, this is a minute of the project board from 13 May 2011. Then if we could look within box 2 to the third last entry, do you see a paragraph beginning "Safety and SGHD expressed…"?

A Yes.

Q So it says:

"SFT and SGHD expressed a strong view that the period indicated for "Competitive Dialogue" did not reflect the production of a reference design and was based on an exemplar design. This period, in their view, needs review with a considerable reduction in duration likely. Action – BC"

Do you see that?

A That's exactly the point I just made. I do recall that, yes, uh-huh.

Q It said "Action – BC", is BC----

A That's me, yes.

Q It's you, and what action, if any, did you then take?

A We shortened the programme, from memory.

Q So what was going to be omitted, what was originally going to take place that was then omitted in terms of the competitive dialogue stage?

A I think it's the amount of dialogue. So it was just to speed things up and not have the same amount of dialogue, essentially. We felt that that was-- that brought risk to the project, brought risk to the quality of the final product. We argued, I remember, at the time, very strongly in favour of maintaining the programme that we advocated.

Q If I could ask you within your statement to look at paragraph 47, please. So paragraph 47----

A Yes.

Q -- at page 216, you state:

"I have been asked whether the adoption of the reference design approach was

unusual given the number of mandatory elements. I would say that it probably was but we were working with an unusual set of circumstances."

So, again, without getting into the real detail, can you just explain why the reference design was unusual but why NHS Lothian considered it was appropriate for this particular project?

A I think, again at the risk of repeating myself, it was the very set requirements that we had to adhere to enshrined in Supplemental Agreement 6 with Consort, that we were unable to pass that on. We were unable to give bidders the latitude of deciding for themselves where they would bring gas, electricity and water into the building or into the site, for example. So we had to be prescriptive, and we took the view that that was communicated to this thing called reference design.

Q Were the Scottish Futures Trust supportive of the decision taken by NHS Lothian?

A I believe so, yes, yes.

Q I'd like to ask you some questions, Mr Currie, about design assurance, which you mention within your statement, so if we could look on perhaps to paragraph 56 of your statement, please.

A Yes.

Q So you state there that there's a programme of briefing activities in 2010 that sets out the extent of engagement and range of topics discussed in conjunction with a note of the clinical representation in these activities and meetings. Then you go on to say, specifically in the final sentence in paragraph 56: "Clinical input would not have referred to SHTM 03-01 and other parameters such as air changes per hour." So, if the clinicians aren't providing that assurance, who is, in terms of the project?

A What that's referring to is clinicians themselves are probably not that conversant generally with very specific engineering requirements, but the clinical output specifications, which are in the health board's constructions requirements, do refer to things like SHTMs; the current at the time, it would be probably 2025 rather than 03-01, the ventilation particular memorandum.

Q One particular design assurance procedure that you mention within your statement is called the "NHS Design Assessment Process", I think it's sometimes called an NDAP. Are you familiar with that term?

A I am, yeah.

Q Could you explain to the Inquiry what is an NHS Design Assessment Process?

A It's used throughout projects in the NHS to assess the suitability of the developing design in terms of architectural quality, things like, "Is the entrance in the right place? Can you find your way to the stairs? What is the overall quality of the environment in terms of contact with the externals, daylight provision?" All these fundamental architectural requirements. It may also look at whether the building services strategy is correct in terms of sustainability, particularly nowadays. So it's quite broad-ranging in its review.

Q Was that review carried out in relation to the project we've been discussing this morning?

A No, neither at the capital-funded stage or the NDP stage.

Q Again, you say that, at paragraph 66 of your statement, in terms-- just to be fair to you, you say that it wasn't done "… because we had already secured business case approval."

A Yes, I think the chief executive's letter was July '10, followed by the SCIM update guidance in 2011. The OBC for this project was approved in 2008, so we were, if you

like, off and running before the need or the requirement for an NDAP was necessary. We just took the same direction of travel when we moved into the NPD stage as well.

Q Okay. So we'll come on and look at all of that guidance that you've talked about; but again, am I correct in understanding that your understanding as project director, is that there didn't have to be an NDAP for the project?

A Correct.

Q Okay. Again, can you just explain again why did you consider there didn't have to be an NDAP?

A Because the arrangements-- or I think it's described in the letter, I need to look at the exact letter, was that projects that were already in-train, if you like, or moving forward would not be subject to an NDAP review, something like that. I can't remember the actual wording.

Q We'll come on and look at it. As I said at the very start, it's not a memory test, Mr Currie, but what I'm interested to know is whose decision was that to make? Was it your decision as project director? Was it the board of NHS Lothian? Was it Scottish Government? Whose decision was it to take it at that point?

A I would assume it was the interpretation of the CEL.

Q When you say "the interpretation", interpretation by?

A By the-- By NHS Lothian, I can't remember who would be involved at the time. It was certainly-- Well, when was it? July '10? So we'd been moving towards the abrupt halt, if you like, wasn't it, in November '10? Yeah.

THE CHAIR: Sorry, I just missed that. Moving towards?

A Sorry, the change in procurement from capital to NPD. I'm just trying to place it in my timeline.

MR MACGREGOR: Again, I appreciate this is a long time ago, and you're very fairly saying your understanding is that it didn't take place, but can you recall if that was your decision, the project board's, or the board of NHS Lothian?

A It wasn't my decision that I remember, consciously making it. It was something that we were doing. I can't remember even when it was discussed, to be honest.

Q So was there a discussion around about whether an NDAP should take place?

A There certainly was. When we moved into the NPD stage, I remember having those discussions with SFT, and I believe there were discussions between SFT and HFS which we were not party to; but there was never any clear-- "Right, you're changing track now. You weren't doing it before, you're going to do NPD now." It would have been slightly odd in terms of timing as well at that stage. Because of the NPD process, we were generating the reference design and there was a design review done, I think as you're aware, by SFT and Atkins, which HFS and A&DS also reviewed, but we wouldn't have-- I'm struggling to say what the NDAP would have been reviewing other than the reference design. The board's construction requirements held a lot of other information that an NDAP would probably have looked at in a capital-funded scheme. They were in development-- early development when the Atkins review was done, from memory.

MR MACGREGOR: Lord Brodie, that's one o'clock. I'm just about to turn to look at the detail of the document, so I think that may be a convenient point to break for lunch.

THE CHAIR: All right. Well, we'll take our lunch break now, Mr Currie, and if you could be back for two o'clock, that would be very good.

THE WITNESS: Of course.

THE CHAIR: Thank you.

(Luncheon adjournment)

THE CHAIR: I understand that some of the legal representatives towards the back of the hearing room have had difficulty hearing. Now, that may have nothing to do with you, Mr MacGregor or Mr Currie, and it may have something to do with our electronics. We have tried to address the electronic side to the extent that that's possible. I am told that the technique is to switch on and switch off. So, as I say, it may have nothing to do with questioner and answerer, but perhaps if you could bear that in mind and sort of keep the voice level up. I think it has been explained to people sitting towards the back of the room, if you continue to have a problem, there is the possibility of using one of our hearing rooms with a remote feed. Apparently, the remote feed is rather effective, so perhaps we can adopt a multidisciplinary approach to the matter. Mr MacGregor.

MR MACGREGOR: Thank you, my Lord. Mr Currie, before lunch, we had just been discussing the NDAP review process, and you had helpfully confirmed, as per your witness statement, that there wasn't an NDAP review done for this project. Could I ask you to have in front of you, please, the outline business case? So that is bundle 3, volume 2 at page 672.

A Yes.

Q That should be the outline business case from 25 January 2012. Do you see that?

A Yes, I do.

Q The Inquiry has heard evidence from Ms Sorrel Cosens, who described herself as the editor of the outline business case. Did you have any input into the outline business case?

A Yes, I would have in terms of the management and some of the technical areas.

Q Would you have reviewed that before it was submitted to the board of NHS Lothian and then went on to the Scottish Government?

A Yes, yes.

Q If I could ask you to have a look, please, at page 685 of the bundle and paragraph 1.70 towards the foot of that page.

A Yes.

Q Do you see that it states:

"The reference design and development of the final design with the preferred bidder will both be subject to a range of reviews as work progresses. To date

these have included the following, and findings from each have influenced the ongoing design development …"

Then do you see the final bullet point on that page, it says "Health Facilities Scotland NDAP – design assessment"?

A Yes, I do, yeah.

Q Is that an error?

A It is in the sense that, as I said earlier before lunch, it was never done. That may have been a hold in the text that was never updated, I'm guessing.

Q Do you recollect seeing that at the time that the business case was produced and when you reviewed it?

A No. I have no recollection, no.

Q Would you be able to assist with-- Ms Cosens had indicated she wouldn't have put that in unless someone had told her to do that. Do you know who that person might have been?

A It could have been me. I can't honestly remember.

Q So we should understand that when this states that there had been the review by Health Facilities Scotland, the NDAP design assessment, that that's just an error?

A The way it's written there, yes. I mean, as I said, A&DS and HFS did review the Atkins report, but that doesn't come close to a full NDAP, no.

Q Yes. Again, correct me if I'm wrong, but the outline business case, that will go to the project board first?

A Yes.

Q And nobody spots that error on the project board?

A Apparently so, yes.

Q It would then go to the Finance and Resources Committee for review?

A I would think so, yes.

Q It would then go to the full board of NHS Lothian?

A Possibly. I don't know about that at the time, possibly.

Q Would it not have to go to the board for the board to approve the business case?

A If-- This was a revision, wasn't it? This was an addendum to the original business case. This is July-- This is January '12, I think we're looking at here, isn't it?

Q This is what is called the 2012 outline business case.

A Yes, yes, but it was a revision of the OBC back in 2008, yeah. I can't recall whether it went to the main board or not.

Q Thereafter, would it go to the Scottish Government?

A Yes, yes.

Q Again, just in your role as project director, do you have any recollection of any party asking you to see the physical document, the NDAP document, referred to here?

A No.

Q Do you find that surprising?

A I do in hindsight now, given that it's written in bullet point 1.70, yeah.

Q If I could ask you, please, to have in front of you the Scottish Capital Investment Manual, the Business Case Guide. So that is in Bundle 3, volume 2 and it begins at page 120. I have got you noted as, before lunch, referring to a "SCIM". In terms of a "SCIM", are you referring to the Scottish Capital Investment Manual?

A Yes, yeah.

Q In terms of this guidance, this is the 2011 guidance. If we look on to page 124, we see at the top of page 124, it is stated that:

> " … an assessment of design quality at IA, OBC and FBC stages is now part of the SGHD Business Case process, the purpose of which is to ensure that the outcomes of development projects meet the Government's objectives and expectations for public investment. The aim of mapping design into the Business Case process is to support the implementation of the Policy on Design Quality for NHS Scotland by improving the level of design quality achieved across NHS Scotland and, ultimately, the outcomes achieved by doing so."

Do you see that?

A I do.

Q What do you understand the Policy on Design Quality for NHS Scotland to be?

A Well, this is the continuation of the CEL of July 2010, which introduced the use of NDAP as part of the SCIM policy and process. The key phrase in the top sentences is it's "now" part of the business case process.

Q We are going to come on and look at the CEL and the supplementary guidance itself. If we then look on to page 129, section 2, we see that it states:

> "This guidance consolidates other reference sources and takes the business case author through the entire process – from

IA, OBC and FBC. The guide is accompanied by a set of templates, prepared following many years of practical experience with a wide range of public sector organisations. It covers the content, presentation and structure of the business case and the standards which need to be applied."

Now, if we skip the next paragraph, the third paragraph, the penultimate paragraph on the page states:

"All projects submitted to the SGHD Capital Investment Group for approval are now subject to an assessment of design quality and functionality, including technical and sustainability standards. This Design Assessment will take place at the Initial Agreement, Outline Business Case and Full Business Case stages of approval."

Do you see that?

A I do.

Q Thank you. The next document I would ask you to please have in front of you is in bundle 4 at page 99. So bundle 4, page 99, and in the top right-hand corner it says, "CEL 19 (2010), 2 June 2010". Again, we will look at the detail of the document, but what was your understanding of CEL 19 in 2010? What was it doing?

A It's introducing the use of NDAP to the government's business case process.

Q If we look at paragraph 3, it says, "This CEL and the attached policy statement supersedes NHS HDL(2006)," which is what we looked at this morning, if you remember.

A Yes.

Q It says, "This CEL also provides information on Design Assessment within the SGHD CIG Business Case process." Then if we look on to page 101, paragraph 11, under the bold heading "Design Assessment and Business Case process":

"An assessment of design quality is now part of the SGHD Business Case process. All projects submitted to the SGHD Capital Investment Group for approval are now subject to an assessment of design quality and functionality, including technical and sustainability standards. This Design Assessment will take place at the Initial Agreement, Outline Business Case and Full Business Case stages for approval."

Do you see that?

A I see that, yeah.

Q Then if we look on to page 102, we see the policy itself, "A Policy on Design Quality for NHS Scotland". If we look on to page 113, we see at page 112 the mandatory requirements start, and on page 113, we have got Mandatory Requirement 7:

> "All NHS Scotland Bodies engaged in the procurement of both new-build and refurbishment of healthcare buildings must use and properly utilise the English Department of Health's Activity DataBase (ADB) as an appropriate tool for briefing, design and commissioning.
>
> [If deemed inappropriate for a particular project and an alternative tool or approach is used, the responsibility is placed on the NHS Scotland Body to demonstrate that the alternative is of equal quality and value in its application.]"

Do you see that?

A I do.

Q Again, my recollection from this morning, when we looked at the 2006 Policy, was that you said it was perfectly normal, in your view, to use the Activity Database, is that correct?

A Standard practice, yeah.

Q Just to be clear, at any point while you were project director, was there any intention on the part of NHS Lothian to use what is described here as "an alternative tool or approach" to the Activity Databases?

A Not when it was in our capital-funded days. When NPD arrived, I think in the Board's Construction Requirements, we asked that the bidders prepare their room layouts based on ADB. So the word "ADB" as a proprietary system is used there, yeah. Of course it was incumbent on the preferred bidder to prepare the room data sheets, not us as the procuring authority.

Q Yes. We will come onto that when we come to consider the procurement exercise. Then if we look on to paragraph 9, "Monitoring":

> "SGHD will monitor the integration of design quality into healthcare building procurement through the Business Case approvals process which will be facilitated through a coordinated assessment of the potential quality of proposed projects to support those responsible for decision making within the Business Case process.

> This assessment will involve the contribution of particular expertise on the aspects of design relating to government policy on design and place-making from Architecture and Design Scotland and, of particular expertise on the aspects of design relating to functionality, particularly technical and sustainability standards, from Health Facilities Scotland."

Do you see that?

A I do, yes.

Q If we look on, just for completeness, to page 136, we see a number of paragraphs at the bottom on Activity Database. Essentially, if I just paraphrase, really making the same point as in the 2006 Policy that if you use the Activity Database, you will automatically comply with English guidance, but you need to be careful to make sure that you comply with the specific Scottish guidance.

A Yes.

Q Again, that was your understanding as at the time the outline business case was being approved?

A Yes.

Q Just to complete the documentation in relation to the NDAP process, if I can ask you to have in front of you, please, bundle 8, page 63. Is that the "Scottish Capital Investment Manual Supporting Guidance: Design Assessment in the Business Case Process"?

A Yes.

Q Bundle 8, page 63. If we look to page 64, please, we see in the introduction, it states:

> "From the 1st July 2010 an assessment of design quality will become part of the business case approval process. This guidance should be viewed as part of the Scottish Capital Investment Manual …"

Then if we look, still within the introduction, just to the final paragraph of the content section, four lines up from the bottom, it states:

> "… it is intended and expected that Boards will develop 'design statements' and utilise the self-assessment methodologies described below on all development projects."

A From that date, yes.

Q Indeed. We will come on and look at the transitional provisions as well. So if we look then onto page 65, section 1, "Design Assessment in the Business Case Process," three lines up from the bottom:

> "These are brought together

in this process, and in the collaboration of HFS and A+DS in the NHS Scotland Design Assessment Process, by the means described below."

Then there is a detailed procedure set out thereafter. At section 1.1, "Compliance with Healthcare Design Guidance," if we look four lines up from the bottom of the final paragraph, it states:

"To facilitate this, Boards will be requested to submit a comprehensive list of the guidance that they consider to be applicable to the development under consideration (see inset on next page), together with a schedule of derogations that are required for reasons specific to the project's particular circumstances."

Was any document like that included within the 2012 outline business case?

A No, because of the procurement route. In terms of the comprehensive list of guidance, that is contained in our what's called Board's Construction Requirements, which were still in development and were only finished, I think, it must have been early 2013 before we embarked on competitive dialogue. So they wouldn't

be available at the stage when this business case revision was made. In terms of the schedule of derogations, there were none at that stage and there were none by us anyway when we began competitive dialogue.

Q If we look over the page onto page 66, what the guidance is stating on page 65 is the list that should be provided, and then we see the documents listed on page 66. So: "Projects submitted for the business case process will be assessed for compliance with the following," and then it includes Scottish Health Planning Notes and Scottish Health Technical Memoranda. So, for the NDAP process, that's what should happen?

A Yes.

Q If we look on to page 68, please, in the full paragraph after the bullet points, just really having filled in some of the detail in terms of what the assessment process will be, do you see wording four lines down in that paragraph beginning "as such it should not be"?

A I do.

Q It states:

"… as such it should not be seen as a replacement for the project team's in-depth consideration of technical and

other standards."

A Yes.

Q Again, was that your understanding of what the NDAP process involves?

A Yes, and still is, yes.

Q So, again, just to make sure I'm understanding things correctly, there is a process that has to be gone through, including listing relevant technical guidance with an assessment being made, but the guidance documents themselves are saying, "There is a review, but it is not a substitute for the body actually making sure that there is compliance with relevant technical standards."

A Yes, that's my understanding, yeah.

Q If we then look on to page 69 to paragraph 1.4 at the bottom, "Transitional Arrangements". So paragraph 1.4:

> "This guidance shall apply to all projects submitted for approval of the Initial Agreement (IA) after 1st July 2010."

So, again, just to make sure that I am understanding you correctly, is your view that the NDAP was not done because the project was already past that stage?

A Yes, that's my understanding.

Q The Transitional Arrangements continue:

> "Projects that have not received approval of their Outline Business Case (OBC) by 1st July 2010 shall be considered for an assessment process on a case by case basis, as part of the initial pilot phase, however the development and demonstrated application of a Design Statement should be considered as good practice for all projects from publication of this guidance."

Do you see that?

A I do, yeah.

Q Again, it is a failing on my part, we covered this this morning, but in terms of this guidance, as I read it, is saying, "Well, you don't have to comply with it; there will be consideration given on a case-by-case basis." So why was this project not suitable for the NDAP review?

A My view would be that there was an assortment of reviews being done by different parties, and the fact that whatever design was being reviewed was going to fall away very quickly at the start of competitive dialogue where we would have three designs to review. So whether there was validity in doing an NDAP on a design that was-- had a short shelf life

is maybe a point. For example, A&DS, who are very much central to the NDAP review in association with HFS, they were part as a statutory town planning consultee with the City of Edinburgh Council, who we invited in during the dialogue phase to assess all three developing designs. A&DS were very much part of that review process, in essence, doing an NDAP arguably at that stage. I wrote to Mike Baxter, I think around about early twenties(?) at the start of competitive dialogue, advising him of this and asking for his confirmation that A&DB did not have another role other than their statutory town planning role during the competitive dialogue. So there were various reviews going on at different times, which probably equated in some people's minds to an NDAP. But, timing-wise, it wasn't the standard capital-funded SCIM NDAP process.

Q Thank you. If I could ask you to please look within bundle 3, volume 3 to page 1310, and to an email at the bottom of that page from Alan Morrison to Susan Grant.

A I see it, yes.

Q The question posed in the second paragraph is:

> "If a new hospital was being designed and the ventilation system in a critical care unit had a non-compliant number of air changes per hour, would the NDAP review pick that up?"

If we then look up page 1309 to the bottom of that page, we see a response from Susan Grant to Alan Morrison. We see in the second line, she says:

> "So quick answer is 'maybes aye – maybe no'
>
> As you know NDAP is only a proportionate review… and we may or may not catch the many many details in each project."

Do you have any observations? If that question was posed to you, would an NDAP have picked up that type of error, what would your response be?

A I think it would be dependent on the information provided for the NDAP review team. In our case, that information was contained in documents that were in the process of being developed through the Board's Construction Requirements. There's another document that comes up-- will come up, I'm sure, more frequently in further hearings called the Environmental Matrix, and that had, as we all know now, an error in it. It is a document that, without going into procurement too much, is classed as disclosable data and therefore

indicative and not warranted in any way by the board. It was given to the bidders along with, I think, a data room of other information of the same status to inform their designers and give them a starter for ten. So, going back to your question, if that Environmental Matrix had been reviewed, I think ultimately there were 2350 line items on our Environmental Matrix. Whether NDAP reviewers would have picked up an anomaly in two or three lines within that is debatable, particularly when Design Note 15, I think, quite clearly stated at the front page of the Environment Matrix that in the case of the anomaly, reference the critical care area, the SHTM 03-01 requirements prevail. So whether that would have satisfied an NDAP review team, I don't know.

Q But, again, you will appreciate that's really the procurement stage and beyond which we are not considering for the purposes of today.

A Yeah. I'm doing my best to answer your questions.

Q Yes. But, again, as I have got(?) you, my understanding of your answer was that in terms of the NDAP review process, the technical information for the ventilation system wasn't that developed----

A Yes.

Q -- at that stage. Is that correct?

A In terms of the Board's Construction Requirements, which is essentially what that information was, given if you're-- I'm sure you recall, we are not preparing any engineering parameters other than reference to SHTMs, so there wouldn't be a design of a building services system for them to review. The only information that would have been potentially available – I can't remember the timing – was that second amendment to the Environmental Matrix, which had the anomaly available to Atkins, who did the approximate review in-- whenever it was, in 2011, I think.

Q Well, if we turn to the Atkins review, if we could look in in bundle 3, please, volume 2 at page 567, you should see a document called "Royal Hospital for Sick Children/Department of Clinical Neurosciences Independent Design Review, Scottish Futures Trust, 12 December 2011." Is that what you are referring to as the Atkins Review?

A That was commissioned by SFT, yes.

Q If we look on to page 571, we see the "Summary and Recommendations". So bundle 3,

volume 2, Atkins at page 567, but if we could pick matters up at page 571, it states:

> "The purpose of this Independent Review was to assess the design brief for the project to replace the Royal Hospital for Sick Children and the Department of Clinical Neurosciences (RHSC/DCN) on the Little France site. The review assessed the capacity of the project to deliver value for money by meeting the strategic aims of the programme; by making best use of space and opportunities for maximising sharing with other assets; and by minimising the whole-life costs."

Do you see that?

A I do.

Q So, although it is a design review, is it really more targeted at I think what one witness has referred to as the "bankability" of the project?

A Yes. I mean, I think I probably referred to this report at the time as SFT's needs-not-wants report. They were keen to impress on us that this facility should accommodate the board's needs, not its wants, if you like. So they were looking at the affordability aspects particularly, which

is in essence what Atkins did, and it was very welcome at the time. They made many recommendations, which we picked up and developed. It is a snapshot in time as well because the reference design was in full flow at the time, so the reference design was not anywhere near finished.

Q Because if we look, for example, on to page 576, approximately two thirds of the way down the page, there's the bold heading "Reference Design".

A Yeah.

Q Page 576. Do you see it states that: "At the point of our review the Reference Design was relatively under-developed considering the stage of the project…"? Do you see that?

A Yes. I don't quite agree with "considering the stage of the project", but anyway, it is what it was at the time.

Q Yeah, so certainly the author of the report considered that the reference design was relatively underdeveloped. Did you share that view of the reference design----

A Yes, at that stage, yeah.

Q If I could ask you to look on to page 637, please. Do you see that there's a coloured table towards the top of the page?

A Yes.

Q In the turquoise colour, at "F", "Engineering".

A Yes.

Q Do you see that it scored zero out of five?

A Yes. That's no surprise whatsoever because there's no engineering to score.

Q Is that effectively why it scored zero, because there's just simply not----

A Yes.

Q -- that level of design at that point?

A Yeah. The reference design would not-- if that's what they were reviewing, did not including engineering parameters, no.

Q If we look at paragraph 7.2.3, it states:

"A number of elements are unable to be scored at this stage because the design is insufficiently developed. In particular performance, engineering and construction cannot be scored at this stage."

A Correct.

Q Is that surprising in any way?

A Not at all.

Q Just for completeness, do you see in the paragraph below it says: "However, some of the elements which have not been scored are surprising…" and then there's some specific examples given?

A So is this in relation to the AEDET review above, context of this, or was this the Atkins review? I'm getting a bit confused. It mentions AEDET in the----

Q I think that's still within the Atkins review.

A Right.

Q If I could ask you, within the same bundle, so bundle 3, volume 2, to look on to page 883, please. This is a document headed up: "HFS Comments on the RHSC/DCN Independent Design Review carried out by Atkins for SFT". Do you see that?

A I do.

Q It's a review, top right hand-corner, by Health Facilities Scotland-- with Health Facilities Scotland providing various comments on the Atkins Review. For example, if you look on to page 884, there's comments in relation to the single rooms.

A I can see that, yes.

Q Apart from this input from Health Facilities Scotland on the Atkins report, are you aware of any other review conducted by Health Facilities Scotland in relation to the design of the project we've been discussing?

A No, no. A&DS reviewed this as well, though. I'm pretty sure of that.

Q If you could assist the Inquiry, what do you mean by----

A Architecture and Design Scotland.

Q What type of review did they conduct?

A I'm not sure, to be honest. I do recall them being involved with it – at a distance from us, of course. I would have thought they would have looked at the things of interest to them which are particularly architectural place making, quality of space, quality of environment, from an architectural point of view, not an engineering point of view so much.

Q If I could ask you to have in front of you, please, within bundle 5, at page 61----

A Yeah, I see that.

Q Bundle 5, page 61. This is an email from David Stillie to a number of individuals, including Thomas Brady, Richard Cantlay and Fraser McQuarrie. Can you assist the Inquiry, who's David Stillie?

A David Stillie was-- David was a senior architect with Mott MacDonald and was very much part of the project team.

Q What Mr Stillie says within this email, if we read it just perhaps from the third line down, it says:

> "No clear way forward came out of the meeting but he did say that everyone present appreciated that RHSC/DCN project had been reviewed 'to death'."

Is that a view that you would share?

A I think I maybe hinted at it earlier in one answer to one of your other questions: there were numerous reviews being undertaken, whether I would've used that exact phrase or not, I'm not sure, but there was certainly enough-- a lot of attention on the project, yes.

Q Still within design assurance and reviews, the Inquiry has consistently heard from witnesses talking about gateway reviews. Could you assist the Inquiry, what did you understand a gateway review was?

A I think I experienced two of them in this project. They were essentially reviews as to the adequacy of the project management and resource and mitigation of risk involved with the project. As I said, I think I was involved with two. When it became-- And that was in-- Sorry, that was the capital funded days; when it became

NPD, they fell away and SFT introduced a key stage review process which we were then engaged on.

Q If we think of the gateway reviews, who's conducting a gateway review?

A It was, I think, four or five people that were brought together from various parts of the NHS in Scotland. I can't remember the individuals' names, but there was somebody from Borders who was a director of capital planning, there were a couple of gentlemen from other NHS boards and from NHS Scotland themselves, experienced individuals. So it was NHS Scotland, the Scottish Health Directorate.

Q So, again, just so I'm clear, when we're talking about the capital project, we're talking about gateway reviews, and then when we're talking about the revenue-funded project, we're talking about key stage reviews.

A And they were managed by SFT.

Q If I can ask you to have in front of you, please, in bundle 3, volume 1, page 797.

THE CHAIR: Thank you.

Q So, we're talking about gateway reviews, is this a document you'd recognise as a gateway review?

A Yes, yes.

Q So, top right-hand corner, we've got the Scottish Government gateway review for the project, and this is Gateway Review 2. We look over the page onto page 798, in the fourth box we'll see that that's a review conducted on 9 March 2010.

A Yes.

Q If we look to page 800, please, we see, at the start of the "Background", the "Aims of the Project", the "Driving Force of the Project", and then, at section 1.3, "Procurement/Delivery Status".

A I see that, yes.

Q It states:

> "The project's Outline Business Case… was approved in August 2008 and thereafter a decision was taken to combine the build of the RHSC with the proposed Department of Clinical Neurosciences… In early 2009 Professional Services Contractors… and a Framework Principal Supply Chain Partner… were appointed to take this combined project forward. In late 2009 Scottish Government Health Department advised that capital funding would not be available for the DCN and the two new builds have therefore been

uncoupled.

The delivery team are now working towards the compilation of a detailed design and target price for the RHSC by the end of 2010, followed by submission of the Full Business Case."

So is that effectively the background to the project as at the point this review is being conducted?

A It is, yes.

Q If we look on to page 801, you see at the top the "Purpose and Conduct of the Review". We then see, in the middle of the page the "Conduct of the Review", and then, at section 3, the "Gateway Review Conclusion". So if we look to the penultimate paragraph beginning: "By comparison…" Do you see that?

A I do, yeah.

Q It states:

"By comparison with our last Review the Core Project Team are now well resourced with experience and compliant construction professionals, complementing the work and strong support of clinical, management and Partnership colleagues. An advisory team is also in place and overall there is more assurance around the ability of the team to deliver."

Do you see that?

A I do.

Q Would that be consistent with your views as at the time this review is being undertaken?

A It was and is, and I think that's a testament to the team growing and building in that intervening period since the last gateway review-- the previous one.

Q If I can ask you to look on, please, to page 803. So we begin at the top of the page with "Experience on this project…"

A I see it.

Q So it says: "Experience on this project has been that HFS…" presumably that's Health Facilities Scotland?

A Yes.

Q

"… support has been useful in some early advice but as the project has developed and the client team has been strengthened by the appointment of experienced and highly capable staff, HFS advisers clearly need to adapt their role. In this case the need to adapt does not appear to have been fully recognised to the extent that they have been seen as 'meddling' in areas of direct

service delivery that are now clearly the remit of NHS Lothian (NHSL) as the client to the contract. This is potentially damaging to the service the client receives from their advisers and needs to be resolved as soon as possible."

Can you just explain why that's included within the gateway review?

A I have no idea. As you were reading it, I was shaking my head. I don't know where that has come from. I can't recall that at all.

Q Is that a view you shared in terms of the input from Health Facilities Scotland in the project?

A No. Health Facilities Scotland were used and continue to be used on an ad hoc and on a needs basis. So where we would want specific, very detailed advice on IPCT or engineering or whatever, we would contact them, and that's-- in my, what, nearly 13 years whatever now in NHS Lothian, that's always been the case and it's never changed. So I have no idea where the phrase "meddling" comes from.

Q Thank you. Then just turning to the key stage reviews that then came in, I think you said that they were conducted either by or on behalf of the Scottish Futures Trust.

A They were conducted by Scottish Futures Trust, yeah, yeah.

Q What would a key stage review involve?

A It was really, "Was the project ready to progress to the next stage? Had we satisfied SFT that all the various--" and I can't remember the detail, but it went through everything, from obviously affordability, readiness for the market, attractiveness to the market, sufficient transfer of risk, everything I spoke about this morning as well. Myself and Sorrel Cosens, who I think you saw yesterday were very much part of that process. They were ultimately in many meetings with the SFT representative, and they-- she then took it to a senior person in SFT who would sign it, and then it was countersigned by the director of finance in Lothian.

Q Thank you. If I can ask you to have your statement in front of you, please, and to look to paragraph 57 on page 218. So paragraph 57, you refer to the NEC3 which you describe as mandated by HFS.

A Yeah.

Q Was the NEC3 contract prescribed under Framework Scotland entered into if an NSS Scotland client chose to enter into a Framework Scotland project?

A I understood it that it was mandatory, that the framework had been based on a procurement and delivery construction route using NEC3 with the five framework principal supply chain partners. So I didn't think there was any ability to digress from an NEC contract.

Q Were you aware of an entity called ARHAI Scotland at any point during the project?

A ARH-- What's that an acronym for? Forgive me.

Q I think it was possibly formerly called Health Protection Scotland.

A Well that's now-- that's NSS Assure's IPCT team, so yes, that sounds like a precursor to that.

Q What did you understand that entity did as at the time of the project?

A The early days, capital funded days or any time?

Q I think just throughout the duration of----

A They-- If it's what I think it is, we-- like HFS on the engineering side, we would have, through our IPCT teams and microbiologists, have consulted them on a needs basis with a specific query, interpretation, if it's----

Q You mentioned IPC. What do you mean----

A Infection Protection Control team.

Q So would that entity of given advice on issues of infection prevention and control?

A Yes.

Q Could you just explain how they would become involved and what involvement, if any, they would have?

A It's been particularly relevant in recent years with the, you know, unfortunate COVID landing on the world and how the healthcare facilities need to be adapted and cope with things like that. So, where there's a very specific or new problem or issue, they would be brought in, or whether there was a clinical need to do something slightly different because of a particular treatment. So they're specialists in the field available to all boards in Scotland.

Q Thank you. If I can ask you to look to paragraph 64 of your statement, please. And you state at paragraph 64 that the, "Two Achieving Excellence Design Evaluation Toolkit (AEDET) Reviews were undertaken on 12 August 2011 and 8 March 2012 …" but you say you weren't directly involved.

A Yeah.

Q Are you aware of any

other evaluations undertaken by AEDET?

A AEDET is a process not an organisation, and it was undertaken by essentially the reference design team led by the architect for the reference design team. It's basically engaging with stakeholders and end users, so we were at pains to make sure that the project team itself, and particularly others that were not directly involved in the reference design, such as myself, working in other workstreams, did not contaminate, if that's the word, the evaluation process – not to unduly influence end users and their thoughts and their views.

Q Would engineering be reviewed through that process?

A No, I don't think so – not on a level of detail anyway.

Q If I can ask you to return to the Atkins report just for one final question in relation to that. If we could look in bundle 3, volume 2, at page 644. If we could look to the bottom of that page at section 7.8: "Building Services and Progress to BREEAM".

A Yeah, yeah.

Q Bundle 3, volume 2, at page 644. Paragraph 7.8 at the bottom, "Building Services and Progress to BREEM":

> "The approach to building services design and progress towards a high BREEAM score was not assessed as it anticipated this will form part of the technical monitoring of the project by both the Scottish Government and HFS."

What's your understanding of that term, "technical monitoring"? What was meant to happen?

A I'm not quite sure, other than the BREEAM rating that we were-- had our ambitions set on was a-- was part of the challenge developing the designs through competitive dialogue. So I'm not sure what they mean by technical monitoring. Sorry, don't know. I think the nearest building services would have would have fallen into Atkins' sights when doing the review was the clinical output specs that were part of that; and within the clinical output specs, there's a reference to the appropriate SHTMs, so I say 2025 it would be in those days for ventilation.

Q Apart from the Atkins review and other documents that we've looked at today, are you aware of whether there were any other engineering or building services technical reviews that were included within the business case presented to

the Capital Investment Group?

A So that would be the January 12 revision. No, not aware of any.

Q Are you aware of any----

THE CHAIR: Sorry, my fault, Mr MacGregor. Your question, that's prior to submission of the outline business case?

MR MACGREGOR: It was really at the point that it was presented to the Capital Investment Group for approval.

THE CHAIR: Okay. Thank you.

MR MACGREGOR: Really, the follow up question I had was whether you were aware of any structures that were in place for technical assessment of proposals at the outline business case stage?

A No. Those technical proposals came later and were finalised later in the board's construction requirements, which was a good year after probably finalisation anyway, after the business case was submitted. I think the business case was approved in September of that year, after we achieved SA6 and SA7; allowed us to proceed to competitive dialogue.

Q We've already considered the issue of key stage reviews, which you mention at paragraph 71 of your statement. If

there were any discrepancies, errors, or issues with a technical design, would you expect that to be picked up throughout the key stage review process?

A Without going through all the check boxes in a key stage review, I would have thought not. SFT were not really interested in the design in that sense; they were-- it was about affordability, deliverability, programme, transfer risk.

Q If I can ask you to look to paragraph 74 of your statement, please.

A Yes.

Q You use the term, towards the end of paragraph 74, the term "significant design assurance". Could you explain what design assurance Mott MacDonald was providing to NHS Lothian, if any?

A Well, they were preparing the board's construction requirements and the invitation to participate in dialogue documentation. So we were relying on their expertise in making sure that the range and accuracy of the standards referred to as mandatory in the project agreement were the right ones, so, yeah.

Q Again, just to be very clear, were Mott MacDonald instructed to verify the environmental

requirements as contained in the reference design in the period prior to the contract notice being issued?

A Can you say that again, sorry?

Q Were Mott MacDonald instructed to verify the environmental requirements as contained in the reference design in the period prior to the contract notice being issued?

A I would imagine they would have been, yes, uh-huh. So the reference design, as I said, it would be very much a strategic-- "Could the building be serviced in general terms by building services distribution vertically and horizontally, and was there adequate plant space allowed for that sort of stuff?" which was all indicative as one potential solution. So if they were asked to verify, that's what they'd be verifying against.

Q Thank you.

A Then if I could ask you to look towards-- at paragraph 72 of your statement, please, on page 222. This is referring to key stage reviews.

A Yes, I see it.

Q You mention there that a Tony Rose completed all of the key stage reviews.

A Yes.

Q Do recall if perhaps Colin Proctor approved the final key stage review?

A Potentially. It was-- I remember Tony more than Colin, but Colin might have done if Tony was, you know, on holiday or something, yeah.

MR MACGREGOR: Thank you, Mr Currie. I don't have any further questions. Lord Brodie may have questions or, equally, there might be applications from core participants. Thank you.

THE CHAIR: Does anything arise out of the questioning of Mr Currie? All right, I'm taking that as a "no". Mr Currie, thank you very much for your evidence, and it's now concluded – at least for this particular hearing. So thank you very much again, and you're free to go. Thank you.

THE WITNESS: Thank you.

(The witness withdrew)

THE CHAIR: Now, Mr MacGregor, you don't plan another witness for today.

MR MACGREGOR: No, my Lord. The only witness for tomorrow will be Mr Reekie and it will be Mr McClelland----

THE CHAIR: Mr McClelland is taking that. Well, we will sit again

tomorrow at ten o’clock, and I look forward to see you then. Thank you.

15:00

(Session ends)