Written Statement

Susan Goldsmith

Introduction

1. My name is Susan Goldsmith. I am currently employed as Director of Finance for NHS Lothian though I will retire in May 2022. I was involved in the project to plan, design and construct the Royal Hospital for Children and Young People (RHCYP) and the Department of Clinical Neuroscience (DCN) (the Project). 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. I have been provided with a list of questions and a bundle of documents from the SHI. This statement seeks to answer the list of questions that are relevant to my role in the Project to the best of my recollection. Some of the events I've been asked about occurred fifteen or so years ago and, given the passage of time, I cannot recall all of the events and documents.

Background

2. I first joined the NHS in 1982 as a graduate finance trainee working within the South East Thames Region. I returned to Scotland in 1991 to work in the (then) Management Executive supporting the establishment of NHS Trusts in Scotland, and eventually heading the Trust Finance Unit. During this time, I was employed by the NHS but was on secondment to the Scottish Office, which was part of the UK Government at the time. After leaving the Management Executive I held various NHS Trust Director of Finance posts in NHS Lothian and NHS Forth Valley. In 2005 I was appointed as Director of Finance at NHS Lanarkshire.

3. I have been in my current role as Director of Finance for NHS Lothian since November 2008. As Director, my primary responsibility is to support the financial stability of NHS Lothian ensuring that financial targets are met. This includes overseeing the financial planning and management of the revenue budget for NHS Lothian which is currently £1.7 billion. I am also responsible for Operational Financial Management including salaries and wages administration, financial services, corporate reporting and internal audit. I also oversee the capital programme and major capital projects, which

included the project for RHCYP and DCN. I was involved in the Project as soon as I started with NHS Lothian and was the Senior Responsible Officer (SRO) on the Project from July 2012 – Feb 2015. The Senior Responsible Officer has to be someone who is very senior in the organisation who can carry the principal responsibility and accountability for delivering a project on the Board's behalf. They chair the project board and make sure that they have the appropriate resources to deliver the project. However, their principal task is owning the service change which the project is supporting or enabling. Before I was in this role, Jacqueline Sansbury was SRO and Jim Crombie took over the role after me.

The need for a new hospital

4. I have been asked why a new hospital was required. The reasons are set out fully in the business case but it was well known that the Royal Hospital for Sick Children (RHSC) and DCN were old and tired buildings that were no longer suitable for the services required.

5. In July 2008, a few months before I joined NHS Lothian, the Board had approved the outline business case (OBC) for the re-provision of RHSC at the Royal Infirmary Edinburgh (RIE) at Little France. The OBC was approved by the Scottish Government in August 2008. It was originally to be funded with capital from the Scottish Government and procured via an established procurement framework, being the national Framework Scotland, which was procured and programme managed by Health Facilities Scotland (HFS). The business case had to be approved by the Scottish Government because it was outwith the Board's delegated authority due to its financial value. At the time the value was £5m, but currently any project over £10 million has to be approved by Scottish Government. Iain Graham will be able to speak to procurement framework in more detail. The previous major project that the Board delivered through the use of this framework was the Royal Victoria building on the site of the Western General Hospital.

6. In parallel, in around 2008/2009, NHS Lothian prepared a separate OBC for the reprovision of DCN from the Western General, to relocate the services to the Little France campus at the RIE. The preferred option of NHS Lothian was to integrate the

DCN build into the same site and re-provision project as the RHSC. The strategic case for a joint build was that it would bring both children's services and adults neurosciences together on to the same site at RIE, providing one major trauma site for NHS Lothian and other health boards who used the service. By joining the RHSC and DCN to the RIE Emergency Department, NHS Lothian could deliver integrated emergency services for all ages on the Little France site, including planning for major incidents and decontamination. With adult and paediatric neurosurgery on site, the combined facilities at Little France met the criteria of a major trauma centre.

7. The Board approved the business case for DCN in November 2009, however, the Scottish Government indicated it should not be submitted at that time. NHS Lothian therefore focussed on the re-provision of RHSC as a capital funded, standalone Project (separate to DCN). The Board had already appointed BAM Construction (BAM) as its Principal Supply Chain Partner (PSCP), Davis Langdon as Lead Advisor and Thomson Gray as Cost Consultant in April 2009, using the established procurement framework (national Framework Scotland, managed by Health Facilities Scotland (HFS)). By November 2010, the Project Team was at the point of submitting a planning application and finalising the contract with BAM for the construction of the hospital to be completed in 2013.

8. However, on 17 November 2010, the Scottish Government announced that there was no capital funding available and that the re-provision of the RHSC would be revenue funded. I had been aware that there was a challenge on the availability of capital funding and that the Scottish Government were considering other funding options but I did not know that this was going to impact on the funding available for the reprovision of RHSC until the public announcement. It was also announced that the new hospital would include DCN. This was welcome news for the Board because the inclusion of DCN completed the service requirement to deliver a full major trauma service at RIE. The Scottish Government were aware that in order to deliver a major trauma hospital site, we needed DCN to be integrated on the site. Prior to the announcement of the change in funding, there had been informal dialogue with Scottish Government colleagues about how to deliver DCN, given NHS Lothian's strategic intent to deliver a major trauma hospital on the RIE site. Although NHS Lothian

welcomed the news of the inclusion of DCN, the announcement of the change in funding also raised concerns about the practicalities of delivering a revenue funded (NPD) hospital project on an existing revenue funded (PFI) hospital site.

9. NHS Lothian were invited to submit an addendum to the existing (approved) OBC for the re-provision of RHSC to incorporate DCN with the preferred option of a combined development for the reasons noted above. The work we had done on the business case and design had to be revisited and redone, which took a considerable amount of time. This was mainly due to the fact that we now had to deliver an integrated building on the site. The business case which had been secured for the RHSC reprovision was always going to be built on car park B, but how the DCN was going to be built and delivered wasn't clear at this point. So the work mostly involved the physical design and infrastructure rather than the business case itself. The OBC for the re-provision of RHSC and DCN was approved by the Board in January 2012 and approved by the Scottish Government in September 2012.

10. I do not know why the Scottish Government changed the funding model but my understanding was that there was insufficient capital from the spending review to support the delivery of a capital funded hospital and that public sector capital was prioritised by Government for other projects, such as the new Glasgow hospital and the Queensferry Crossing.

11. It would not be usual for the Board to be formally consulted in relation to such decisions as it was a policy change determined by government. However, what is more unusual is that we were not given any advance (private) notice of the public announcement. If we were consulted, we would most likely have reiterated our concern about the additional complexities of delivering a revenue funded (NPD) project on a revenue funded (PFI) site, managed by Consort (although this was known by Scottish Government colleagues). These complexities were mainly in relation to the multiple stakeholders involved in a revenue funded project (whether PFI or NPD). In particular, the lenders, shareholders, and their advisers, and the assessment of the differing risk profiles adopted by all. An example is the issue of how the two sites were going to be joined together. Consort would not accept the risk of the new RHSC building being

joined to the exterior wall of the RIE, particularly as this meant breaking through the wall of their hospital. The eventual solution was a mini extension built (known as the "nib"/docking station) from the RIE to which the new RHSC could be adjoined.

12. This was further complicated during the negotiation of Supplemental Agreement 6 (SA6) and Supplemental Agreement 7 (SA7) (explained below) by the fact that we did not have an NPD partner at the time and so in essence NHS Lothian was alleviating Consort of risk, prior to procuring an NPD partner. I am not sure any party (including Scottish Government) anticipated the complexities of these negotiations, and as the statutory authority with the contractual rights and obligations in place with Consort it was our ultimate responsibility to ensure that the interests of the Board, and taxpayer, were protected as far as possible.

13. It would have been helpful to have had some dialogue about the change of funding with Scottish Government before it was announced to discuss some of the potential challenges this might pose for the Board. After the announcement, we did discuss our concerns with Scottish Government. This was largely through face to face conversations with Mike Baxter, who was our direct contact regarding Capital Investments, John Matheson as Director of Finance, and with SFT. These discussions were mainly to advise/consider the challenges that the change in funding brought in terms of complexity but also to ensure they were briefed on key issues/practical implications as they emerged. At the time I knew the project was going to be more difficult to deliver, but I had no idea just how difficult.

Site Constraints

14. There were significant site constraints identified by NHS Lothian during the process of developing its plan to deliver the Project. These constraints included the physical space available, the topography of the site, and the need to adjoin and physically integrate with the existing RIE. These site constraints existed when it was a standalone project for the re-provision of RHSC but the physical scale of the project was increased further by the inclusion of DCN in the Project, which added more pressure on an already constrained site. However, despite these constraints, it was the Board's view

that the benefits offered by delivering a major trauma centre, with its safety and quality benefits, adjacencies and proximity to University teaching facilities, outweighed the disadvantages of the constraints.

Enabling Works (SA7)

15. To overcome some of the site constraints, we identified that there should be a number of common interfaces between RIE and RHCYP and DCN. This has been achieved by a physical connection between the buildings by two linking corridors on the ground and first floor; clinical and operational connection via patient pathways and staff communications; and common infrastructure such as security/fire alarm systems and the pneumatic tube delivery system employed by NHS Lothian on the RIE site.

16. Given the limitations on the physical space and footprint of the site, there was also a need to integrate some of RHCYP and DCN services within the existing RIE, for example adult critical care for DCN patients (ITU/HDU) is provided in RIE (accessed via the linking corridor noted in the paragraph above). However, in order to create space for the additional beds required within critical care for DCN, RIE had to move some cardiology services elsewhere within the hospital. RIE also had to reconfigure its internal and external physical set up to create more space, in particular the entrance to the Emergency Department, to support emergency care services for DCN and Paediatrics. In addition, support services such as the pharmacy and laboratories are also provided by existing RIE departments rather than duplicating them in the RHCYP and DCN.

17. The majority of the enabling works were agreed via a further Supplemental Agreement (SA7) between the Board and Consort, however the works themselves were carried out by one of Consort's equity investors, Balfour Beatty. Some of the internal enabling works, for example RIE Critical Care, Renal and Pharmacy, were not part of SA7 but were delivered by Consort via the mechanism in the Project Agreement of Trust Additional Works Orders (TAWOs). The Project Director, Brian Currie, is better placed to comment on the technical site constraints and enabling works than me.

Supplemental Agreement 6 (SA6)

18. The intended site for the construction of RHCYP and DCN was on Car Park B (as it had previously been allocated for the RHSC as a standalone project) and the crèche adjacent to the existing RIE. In order to secure the land for the construction of the RHCYP and DCN, a variation to the existing PFI Project Agreement had to be agreed with Consort. As part of the existing PFI arrangement, the land was leased by the Scottish Ministers to Consort.

19. In addition, building the RHCYP and DCN on car park B meant that additional (new) car parking had to be provided for RIE before construction could commence. A new car park for RIE was approved to be built on Plots 14 – 16 (referred to as car park F). The plots were part of what is known as the Edinburgh Bio Quarter, with land owned by both Edinburgh University, and Scottish Enterprise, and with a Development Agreement in place with Alexandria Real Estate (ARE). In very simple terms, one aspect of SA6 was a "like for like" swap of car park B for car park F. However, the acquisition by NHS Lothian of car park F was very difficult and negotiations were protracted and complex and took around 2 years from initial approval of the Finance and Performance Review committee in August 2008 to completion of the purchase in July 2010.

20. Once the purchase of the car park was complete, the construction of the car park was required. The construction of the car park was tendered in October 2010 and completed by June 2011.

21. I have been asked whether the negotiations surrounding the purchase of car park F and SA6 and SA7 became my focus (Bundle 3; volume 1; document number 2; page 39, para 64). Plots 14-16 for Car Park F had already been secured but in terms of SA6 and SA7 the answer to that is yes, in relation to the project. Without securing the land, and associated rights, and without delivery of the enabling works we would have had no project. So from both a Board and Executive team perspective my role was to secure SA6 to allow the Board to commence the procurement of the NPD, and SA7 to facilitate the required infrastructure for the Project. This was a priority for me during

a large part of 2011 and 2012, notwithstanding my other responsibilities as Director of Finance. Throughout, my intent was to ensure that the interests of the Board were protected as far as possible, given the imperative to deliver the Project, and to achieve this within a reasonable timescale. The latter objective was not always within my gift.

Impact of negotiations with Consort

22. NHS Lothian were reliant on securing legal and commercial agreement with Consort to provide the land via SA6, and the associated access and interface issues, and securing the enabling works required in SA7, before SFT would endorse NHS Lothian moving to the procurement stage of the Project. This would have been attached to SFTs Key Stage Review (KSR) process. This agreement was also reliant on the conclusion of the reference design incorporating DCN given the requirement to specify the access and interface issues, in addition to the scope of the enabling works required for SA7.

23. I think the fact that there was to be another PFI provider (albeit via a NPD model) introduced more commercial issues for Consort to be resolved. I have no doubt that the legal and commercial issues with Consort would have been more difficult than we initially assumed for the re-provision of RHSC using a capital funded model, however we would have been able to use the national Framework Scotland contracts to deliver the works more quickly, and it is likely that we would have progressed the requirements of Consort incrementally. Consort's own due diligence process with their Lenders took a significant amount of time, and despite agreement of both parties on the key terms of SA6, agreement of one of the Lenders was difficult to secure. I discuss the impact of the negotiations with Consort on the timescales below. A small example of the commercial considerations for Consort was the likely impact of footfall from the new hospital through the RIE and what this might mean for their profile of maintenance and lifecycle investment.

Scottish Futures Trust

24. A couple of months after the change in funding was announced, I co-authored an RHSC & DCN provision project update for the Finance & Performance Review

Committee (F&PR) meeting on 12 January 2011 (the project update) (Bundle 3; volume 2; document 34(i); page 314), along with Jackie Sansbury (Chief Operating Officer). The project update sets out an overview of the progress made since the announcement.

25. Scottish Futures Trust (SFT) were to take a central role in the capital infrastructure programme across Scotland. One of the key matters that was still to be clarified at that time was the explicit roles and responsibility of SFT and the distinct Board appointed technical, legal and/or financial advisors. The project update notes that immediately following the announcement I made contact with SFT, and a meeting took place with the Chief Executive (Barry White) of SFT on 23 November 2010. This covered a range of issues which required to be resolved/considered following the announcement of NPD, including: scope of the Project; interface with the existing PFI contract with Consort; the impact on the enabling works with the inclusion of DCN; work to date with the PSCP; the team and resources required; process and governance; and, fees and revenue support. This was subsequently followed with a number of meetings with representatives from Scottish Government Health Finance Directorate and SFT, as well as ongoing dialogue with our legal advisors and HFS as managers of Framework Scotland.

26. The SGHD letter of 22 March 2011 (Bundle 3; volume 2; document 43(i); page 377) provided "key conditions and guidance" for how we were to develop and deliver of the Project. This was the only document (as far as I can recall) that defined the scope of SFT's role. An early clarification was that SFT were not in a position to provide formal legal, technical, or financial advice to the Board as the statutory authority ultimately being the contractual partner with the Special Purpose Vehicle (SPV) delivering the NPD funded project. The Board required to appoint their own advisers for this. In summary, we were to be supported by SFT, who were to provide the "expertise and advice on the development, funding, structuring, procurement and management of the project". We were asked by the Scottish Government to work closely with SFT throughout the development of the Project, which we did. The input from SFT at this stage of the Project, was instrumental in determining the scope of SA6, and what was required for SA7. SFT's approval was required at

specific points to proceed to the next stage in delivery of the Project (key stage reviews), including the point at which we could proceed to procurement. In essence this introduced a level of oversight beyond that for a capital funded project (at that time), and we engaged fully with key individuals in SFT.

27. The main impact of the change in funding was the change in procurement route available to us and so initially we spent time considering the options available to us. As set out in the project update, our objective was: to minimise both the delay to the programme and the abortive and on-going costs; to ensure operational effectiveness going forward; and, also to manage the overall site consistent with the aims of the Bio Quarter development. To achieve this, we explored the procurement options with both SFT and SGHD for an NPD model to deliver RHSC and DCN, utilising the existing design team to complete the design process. We also considered an option for a Joint Venture with Consort on the delivery of DCN as an extension to the RIE PFI. We took specialist legal and technical advice on these issues (Bundle 3; volume 2; document 34(i); page 318). The Project Director, Brian Currie, is best placed to speak to the reference design.

28. I wrote to the Regional Director of Consort Healthcare, Stephen Gordon, on 2 June 2011 summarising the position in relation to the "Key Enabling Requirement for Delivery of the Project at Little France" (Bundle 7; Document number 6; Page 285). The letter sets out that we had advice from SFT borne out by our advisors that the procurement of the Project must take place via a competitive dialogue process, since no other options were deemed possible, having fully considered and discounted the Joint Venture (JV) proposals tabled by Consort. The letter continued to set out the key issues required going forward, including: land, access, enabling works, and other project and operational management issues.

29. There is a letter from Peter Reekie at SFT to Jackie Sansbury, the then Chief Operating Officer for NHS Lothian (Bundle 3; volume 2; document 46; page 399) dated 1 June 2011, which sets out further details regarding the role of SFT in the Project. Notwithstanding this there had been significant engagement with SFT on

all these matters prior to the issue of this letter. SFT brought a level of expertise to the Project which we welcomed, particularly in relation to the scoping of SA6 and the subsequent negotiations with Consort. This was mainly in relation to their knowledge of revenue funded projects for infrastructure investment and the fact that SFT had essentially designed the new NPD model for Scottish Government. We had experience of delivering revenue funded projects, using the PFI model, however the NPD model was a revised version of a revenue funded model. Our main contacts were Peter Reekie, the Director of Finance, Donna Stevenson, lawyer, and Andrew Bruce, a PFI finance expert. With the appointment of the Board's legal, technical and financial advisers we did have access to our own support for these matters, as we would for the delivery any revenue funded model. These advisers are appointed for their expertise and, importantly, their formal professional advice to the Board. SFT, as an agent of Scottish Government, owned the application of the new NPD model working with both the public and private sectors. SFT advised that we could not finalise the OBC (and hence proceed to procurement) prior to SA6 being concluded in order that the Project was attractive to potential bidders.

30. The engagement with SFT, through meetings and correspondence was initially with Peter Reekie, as SFT's Director of Finance. He attended our Finance and Resources committee at one point to give an overview of what the NPD model was and how it was to be delivered, although this may have been at a much later stage in the project. If there were any issues or complexities, then as Director of Finance and then SRO for the project, I would phone/meet with Peter for advice. I probably had more engagement throughout the project with Peter than anyone else. At the early stages, Donna Stevenson was very involved and attended many meetings with the team and indeed contributed as part of the team. SFT also seconded an individual, Gordon Shirreff, to the NHS Lothian Project Team for a few days a week for a short period. He was asked to come in to support and be part of the project team because he had PFI experience. After this short period, it became clear that the team, with advisers, already had a sufficient mix of experience and his role was no longer required.

31. If we had continued with the capital funded model, the Board's accountability for delivery of the Project would have been directly to Scottish Government Health. The

introduction of the NPD model for delivery meant that there was an additional level of scrutiny and challenge from SFT as a non-departmental public body of the Scottish Government through the conditions set as part of the key stage review process, and in particular the access to funding for the Project. However, as we were the first major acute hospital to utilise the NPD model, and although Dumfries Hospital ultimately completed before us, the Board's knowledge and experience of the requirements for a complex acute tertiary hospital were equally important. This had to be translated into our ask of the NPD model and so SFT were also reliant on us to ensure that the NPD model was effectively adapted for an acute hospital. In essence we worked together to deliver the project.

Delays

32. I have been asked whether the switch to NPD resulted in delays to the Project. It is my conclusion that it did. Regardless of which funding model was used, NHS Lothian would have had to secure the legal and commercial agreement of Consort to SA6 and SA7, and the enabling works associated with the development of the RHSC. Both SA6 and SA7 with Consort were concluded and signed by the end of 2012 (August 2012 and December 2012 respectively) at which point the Board was able to commence the procurement of an NPD partner. The enabling works then took around 18 months from spring 2013 to autumn 2014.

33. However, there are a number of factors that I believe had an impact on the timeline. The first was the time taken to understand more fully the impact of utilising an NPD vehicle for procuring RHCYP and DCN, the contractual implications for our PSCP, and the utilisation of the reference design; secondly the requirement to redevelop the reference design to incorporate DCN, and fully understand the impact on the requirements of Consort: and finally the requirement to resolve all interface, access issues and enabling works with Consort prior to commencing procurement of the NPD partner was extremely time consuming and difficult.

34. There was more work for the Board and principally the Project team as a result of the change in funding. Indeed, the letter from SFT to NHS Lothian dated 1 June

2011 Bundle 3; volume 2; document 46; page 399 makes the point that delivering revenue funded projects brings significant additional demands on the Project team and that would be our experience. Some specific examples that added to the complexity of delivery was the need for both expert legal and financial input on our specific requirements for the Project Agreement, and the associated Financial model; and the requirement to review and prepare for a new procurement process. We also had to plan our requirements for a 25-year period in relation to the ongoing Facilities Management with the contract that would be in place with the successful SPV, and in particular we had to enter a structured, but time consuming, process of dialogue with 3 bidders prior to selecting a preferred bidder.

35. However, I would also acknowledge that, prior to the announcement in 2010, although we were ready to finalise our contract with BAM, I had not appreciated the significant amount of negotiations we still had to undertake with Consort re SA6 and SA7. These negotiations with Consort took in excess of 18 months but I believe were more complicated, and hence took longer, due to the novel nature of delivering an NPD hospital on an existing PFI site and associated commercial implications assessed by Consort.

36. The other main delay was the unexpected inclusion of DCN in the Project. That required the preparation of an addendum to the business case and a revised reference design. All of the work on the business case and design had to be revisited and redone, which took a considerable amount of time.

37. I have been asked whether this Project was particularly complex from the outset and I would confirm that it was, for all of the reasons set out above.

Costs

38. We have not undertaken a financial evaluation of the impact of delivering the Project through NPD as this was the only route available to us. Notwithstanding the inclusion of DCN which had an impact on the construction cost (via the Unitary charge) and associated enabling works required there were other cost implications.

This includes the cost of technical, financial and legal advisers, the increased Project team costs because of the impact on the programme, Consort's legal and technical costs associated with a more complex Supplemental Agreement, which the Board was required to fund, and the time associated with the input required from a number of senior individuals in the Board. This was very significant over a long period of time.

STATEMENT OF TRUTH [to be signed by witness once statement is finalised]

I, Susan Goldsmith, confirm that:

(i) The contents of this statement is the truth to the best of my knowledge and recollection;

(ii) I am willing for this statement to form part of the evidence before the Scottish Hospitals Inquiry.

(iii) I am willing for this statement to be published on the Scottish Hospitals Inquiry website.

Signature:

Date