SCOTTISH HOSPITALS INQUIRY

Witness Statement of

Peter Reekie

In response to Rule 8 Request dated 1 March 2022

28 April 2022

Professional background

1. My name is Peter Reekie. I am the Chief Executive Officer (**CEO**) of the Scottish Futures Trust (**SFT**). SFT is a company wholly owned by Scottish Government, working with organisations across the public and private sectors to plan infrastructure investment; innovate in the funding, financing and delivery of social and economic infrastructure; deliver major investment programmes and improve the management and effective use of existing assets.

2. I have held leading roles in SFT since its inception in 2008 initially as its first Director of Finance & Structures and then as Deputy CEO and Director of Investments from 2014. I have held the role of CEO since 10 January 2018. During the time of the pre-procurement phase of the Royal Hospital for Children and Young People (**RHCYP**) / Department of Clinical Neuroscience (**DCN**) Project (**Project**), that is the phase to which this witness statement relates, I was the Director of Finance & Structures and led SFT's work on the NPD Programme. Prior to my involvement in the Project and my role at SFT, I worked in an advisory role at PricewaterhouseCoopers (PwC), including acting as Financial Advisor on PPP hospital procurement. I worked at PwC for 9 years prior to joining SFT and prior to that worked in a civil engineering consultancy.

3. I have a Masters of Engineering Degree in Engineering Science and a Diploma in Organisational Leadership from the University of Oxford. I am a Fellow of the Institution of Civil Engineers and sit on SFT's Board.

4. SFT is an executive Non Departmental Public Body of the Scottish Government. It is a company limited by shares and wholly owned by the Scottish Ministers. Its activities are overseen by a board appointed by the Scottish Ministers. SFT was established by the Scottish Government in 2008. The Management Statement and Financial Memorandum dated 26 October 2009, agreed between Scottish Government and SFT, (Bundle 7, doc 1 p.9) provided that:

"The aim of the Scottish Futures Trust is to improve the efficiency and effectiveness of infrastructure investment in Scotland by working collaboratively with public bodies and commercial enterprises, leading to better value for money and providing the opportunity to maximise the investment in the fabric of Scotland and hence contribute to the Scottish Government's single overarching purpose to increase sustainable economic growth.

The SFT will act across all phases of the infrastructure investment cycle: needs identification, options investigation, investment appraisal, procurement, financing, design, construction, life cycle management / maintenance and disposal with a particular focus on planning financing and procurement."

SFT's activities are mainly funded by a grant from the Scottish Government.

5. Barry White was SFT's Chief Executive until December 2017, when I replaced him.

Summary of Role of SFT

6. A programme of investment using the non-profit distributing public private partnership model (**NPD model**) was introduced in the Scottish Government's draft 2011-12 budget (Bundle 7, doc 2 p.51) following recommendations of the Independent Budget Review group (**IBRG**). The IBRG was commissioned by the Scottish Government to inform decision-making in relation to the Scottish budget in the face of anticipated reductions in the available resources.

7. The IBRG report recommended:

- an enhanced role for SFT; and
- use of alternative financing models, including the NPD model.

8. Following the IBRG's recommendations, Scottish Government requested that SFT support the delivery of the £2.5bn revenue funded NPD Programme.

9. In leading the NPD programme, SFT performed two distinct roles: (i) a project assurance role; and (ii) a guidance and advice role.

10. These roles were performed at three distinct levels:

- Programme Level: Support to Scottish Ministers and to the Capital and Risk Division of Scottish Government at a strategic programme level;
- Portfolio Level: Support to sponsor departments in the delivery of revenue funded projects; and
- Project Level: Support to individual project teams.

11. SFT is also responsible for appointing the Public Interest Director to each project.

Overview

12. In this statement I will provide answers to questions posed in the Rule 8 request dated 1 March 2022, as follows:

1. SFT's Role - Governance and decision making;
2. Overview of SFT role in development/approval of Outline Business Cases (**OBC**);
3. Individuals from SFT involved in development of OBC;
4. Overview of Key Stage Review (**KSR**) process;
5. Site constraints and contractual dispute with Consort;
6. Switch to NPD Model;
7. Reference Design;
8. Design Assurance; and
9. NHS Design Assessment Process (**NDAP**).

SFT's Role - Governance and decision making

13. SFT was the NPD programme lead for the Scottish Government. The Project formed part of the NPD Programme. The SFT team for the Project was led by myself and at that time I reported to the then Chief Executive, Barry White, who was accountable to SFT's Board.

14. In terms of the governance between SFT and NHS Lothian, it was stated in the attachment to an email issued by Barry White to James Barbour, Chief Executive of NHS Lothian, on 22 July 2011 that SFT would perform a dual role in relation to the Project. SFT's note entitled, "*Role of SFT in Project Delivery – RHSC/ DCN Project*" dated 21 July 2011 states at paragraph 1.1(Bundle 7, doc 8 p.293):

"*Scottish Futures Trust has a dual role in relation to the Project. It has been established as a national centre of expertise in infrastructure procurement and it is in this role that SFT will seek to provide advice to NHS Lothian ('the Support Role'). This role is generally fulfilled through attendance at key project meetings as part of the governance*

process of the Project (we currently attend both the Working Group and Project Board), as well as ad hoc support on other tasks agreed with NHS Lothian.

It also has an oversight role for the Project in acting as a guardian of value for money for Scottish Government ('the Oversight Role'). This role is generally fulfilled through the carrying out of key stage reviews ('KSR') for the Project and by providing input to SG's Capital Investment Group when they are considering the approval of the Outline Business Case and Full Business Case for the Project. SFT also sits on the Infrastructure Investment Board (IIB), which has an oversight role over all infrastructure procurement in Scotland.

There are 4 KSRs being proposed for the Project and the objective of these reviews is to check that organisationally and commercially the Project is ready to progress to the next stage in the procurement process. These KSRs will take place pre OBC, pre OJEU, pre Invitation for Final Tenders and pre Financial Close. It is possible that any of these KSRs may indicate that certain identified issues should be addressed before the project can progress. Each KSR as a matter of course will be distributed to the Project Team and to the Capital Investment Group.

SFT's Oversight Role also extends to the terms of the standard NPD project agreement and the financing terms agreed with the preferred bidder. SFT will discuss with the project team any changes requested by bidders to the standard contract and indicate whether these are acceptable. With regard to the financing terms, we reserve the right to call for a debt funding competition during the preferred bidder period and would expect to approve the terms of the interest rate swap at financial close.

We expect that most of these matters, arising either from the Support Role or Oversight Role, are of sufficient importance to the Project that they would be resolved at project team level between NHS Lothian and SFT. This has certainly been our experience elsewhere. Where such agreement doesn't exist, a dialogue between the Chief Executives of SFT and NHS Lothian should take place to attempt to address any issues.

In the unlikely event that agreement on key issues cannot be reached then a three way discussion would take place between the Chief Executives of SFT and NHS Lothian and the Finance Director of NHS Scotland. Beyond that, referral to firstly the Infrastructure Investment Board and secondly Ministers remain as options should very significant issues remain unresolved.

The benefit of SFT's dual role is to reduce the chances of significant issues being raised during the approvals process or elsewhere and therefore reduce the chances of delay to the Project. We aim to undertake these roles as part of a cooperative and respectful relationship between SFT and NHS Lothian and in so doing improve the chances of a successful delivery of the Project."

SFT's role was also clearly set out in a number of additional documents, including:

(i) the letter from the Scottish Government to the NHS Health Board dated 22 March 2011; (Bundle 3, vol.2, doc 43(i), p.377)

(ii) the letter from me, on behalf of SFT, to Jackie Sansbury, of NHS Lothian, dated 1 June 2011; (Bundle 3, vol.2, doc 46, p.399);

(iii) the email exchange referred to in this paragraph above between Barry White (SFT Chief Executive) and James Barbour (Chief Executive of NHS Lothian) on 22 July 2011; (Bundle 7, doc 9 p.295);

(iv) the SFT note entitled "Role of SFT in Project Delivery – RHSC/DCN Project" dated 21 July 2011(Bundle 7, doc 8, p.293); and

(v) in the Revenue Funded Projects guidance. (Bundle 3, vol.2, doc 43, p.388)

I do not recall any stakeholders raising substantive concerns at the time about the dual roles performed by SFT. Similarly, I do not recall any stakeholders raising such concerns with Scottish Government, on whose behalf SFT was managing the NPD programme. SFT put in place an escalation route for NHS Lothian at an early stage in the process in relation to its dual roles. That escalation route is set out in the "*Role of SFT in Project Delivery – RHSC/DCN Project*" note dated 21 July 2011. I have no recollection of the escalation routes ever being used.

15. I have been asked to comment upon the Grant Thornton Report, at paragraph 315, (Bundle 3, vol.1, doc 2, p.63) which states:

"*Between 2010 and 2014 Scottish Futures Trust were represented on the NHS Lothian project board providing advice and supporting decision making. Alongside this role, they were providing independent assurance. Whilst each key stage report has a second reviewer, there may remain a potential conflict in fulfilling both roles*".

In response to this, I would refer you in general to the shared understanding of SFT's dual role established at the outset and set out above, and specifically for the KSR process, to SFT's guidance titled "*Project Assurance*" dated May 2013. This document sets out SFT's approach to resourcing of KSRs and preserving the integrity of the independent assurance. That document states as paragraph 7 (Bundle 7, doc 30, p.684);

"7. ***SFT Resourcing of KSRs***

As outlined above, KSRs provide a formal checklist for project teams to consider in relation to their project and also provide a benchmarking opportunity to test the readiness of projects in advance of key milestones in the procurement process. They are designed to require the reviewer, as well as the reviewee, to consider whether the project teams: a) have sufficient clarity over the requirements of the competitive dialogue process, b) have the necessary information and resources available for the tender process to be run efficiently and c) are satisfied that the project will produce a good

value for money outcome. In order to ensure a degree of separation between the immediate project team and project sponsoring department and to incorporate external commercial expertise, KSRs were traditionally undertaken by PUK based on the review of paper submissions completed by the project team.

Following its establishment in late 2008, SFT has grown into a fully resourced organisation and now directly employs a dedicated team with both commercial and technical expertise previously unavailable within the public sector. As a result the need to bring in external expertise (at additional cost) as part of the KSRs has disappeared and instead SFT resources KSRs by assembling a small team internally to undertake each review. These review teams normally consist of individuals not directly involved with the specific project. This approach ensures that KSRs are carried out with no external cost to SFT or the project sponsor. In addition, in line with SFT's evolving approach to supporting the revenue funded investment programme the approach to carrying out validation was remodelled during 2011 to remove the burden on project teams in providing additional background information together with completed KSR checklists to reviewers unfamiliar with the specific circumstances of each project. These KSR checklists are now completed by the relevant SFT staff member as part of his or her ongoing project support role. This reduces the overall delay impact of reviews and ensures that the review process is integrated into the overall project development. It also allows relevant aspects of the review to be considered on an ongoing basis. In order to preserve the integrity of independent assurance each KSR report is separately reviewed and signed off by a member of the SFT senior management team unconnected with the project. Consequently, the KSR pro-forma checklists have been updated and relevant guidance made available to project teams as well as SFT staff members undertaking KSRs.

The approach has now been fully operational for 12 months and feedback from project teams and sponsors has been entirely positive."

In my view there was no actual or potential conflict of interest arising from SFT's dual roles in the Project. For an actual or potential conflict of interest to arise, one must be

able to define and identify two separate interests that were or could potentially be seen to be in conflict with one another. SFT had a single interest in the Project, which was to maximise value for money and deliver a workable programme.

16. In general, the "support" element of SFT's role was more significant for the Project than for many others in the NPD programme, and I would point to three reasons for that.

i) The Project was the first acute healthcare project in the NPD programme and, therefore, certain aspects such as the payment mechanism within the contract were being refined for the healthcare sector;

ii) The site already identified for the Project overlapped the site of the existing Royal Infirmary of Edinburgh (**RIE**) which was a PFI project, and SFT's expertise in projects of that nature was used to support NHS Lothian in resolving those project-specific site issues (see paragraphs 54 to 70 (Site constraints and contractual dispute with Consort) below).

iii) SFT set out in my letter to Jackie Sansbury of NHS Lothian of 1 June 2011 (Bundle 3, vol.2, doc 46, p.399) that we did not consider the project team for the Project to have "*sufficient experience of PPP project delivery*". We advised that the "*skills and experience of the Project Director and the wider project team are of vital importance in delivering the Project successfully. A key part of this is experience in delivering revenue funded projects, as this brings significant additional demands on the project team over and above those required on capitally funded construction projects*".

In the short-term this led to the informal secondment of a member of SFT's team to support the project (paragraph 34 below) and in the longer-term, SFT provided more support on this Project than perhaps would otherwise have been the case.

Overview of SFT role in development/approval of the OBCs

17. For major capital projects, such as the building of a new hospital, organisations in the public sector require budget allocations in order to deliver the project and there must be governance around approvals to proceed. Accordingly, there has to be a governmental process of allocating those budgets and giving approvals. The central process of allocating budgets for major capital projects and governing approval to proceed is done through the business case process. Once the business cases are approved, the necessary budget will be allocated to undertake the project. Approvals are managed in stages with the OBC evaluating options and leading to an approval to proceed to procurement and the Full Business Case (**FBC**) setting out the finalised parameters of the investment leading to an approval to enter into a contract.

18. In my view, an OBC process falls into three phases: (i) development; (ii) evaluation; and (iii) approval.

19. SFT had a supporting role in the OBC process, providing comment to Scottish Government as part of the evaluation phase. This was set out by Scottish Government generically for all health NPD projects in the '*Scottish Government Funding Conditions for Delivering Projects through the Non Profit Distributing ("NPD") Model'*, issued to NHS Scotland Board Chief Executives and Directors of Finance, dated 22 March 2011 (Bundle 3, vol.2, doc 43, p.376).

20. The SFT's role during the OBC was clarified to NHS Lothian in a letter from me, on behalf of SFT, to Jackie Sansbury of NHS Lothian dated 1 June 2011, (Bundle 3, vol.2, doc 46, p.399), which confirmed that SFT would review and provide support to the Scottish Government's Capital Investment Group (**CIG**) in its evaluation of the OBC and that such comments would include whether, from SFT's perspective, there were any issues that should be rectified prior to the approval of the business case. This letter further confirmed that, ahead of the formal submission of the business case, SFT was willing to work with NHS Lothian in the development of those documents. SFT "*discussed the contents of this*

letter with the Scottish Government Health Directorate" as stated within that letter (page 1 of 10, para 1).

i) OBC Development

21. Part of our role was to help and support procuring authorities at the project level. In the development of the OBC, this help and support was given, in particular, with regards to NPD-specific elements. The main area in which SFT provided assistance was in the development of the shadow bid model, which is used to understand the affordability of the Project. That shadow bid model was an Excel-based financial model produced by NHS Lothian's Financial Advisors. It contained a number of financial assumptions and had to be structured in such a way as to make it as accurate as possible when calculating the shadow unitary charge, being the amount which the shadow bid model estimated that the procuring authority would pay each year for the hospital. The majority of SFT's work with NHS Lothian at that stage was to help them structure what, in the end, would be seen as an acceptable shadow bid model which would accurately represent the affordability of the NPD project. The shadow bid model included costs for the construction and operational phases and financing assumptions used to calculate the unitary charge, payable over the 25-year contract term. SFT, as managers of the NPD programme, particularly in relation to the financing aspects, provided NHS Lothian with some of those assumptions and provided some help in the approach to modelling. NHS Lothian would have then used its own financial advisors to utilise those assumptions to finalise its model.

22. Involvement of SFT team members during the development of the business case by NHS Lothian and its team was to provide early challenge and guidance with a view to streamlining the appraisal stage, in which increased re-work by NHS Lothian would have been likely to be required had SFT only become engaged at that later stage. The organisation with overall ownership of and responsibility for the business case was NHS Lothian, as the procuring authority.

ii) OBC Evaluation

23. Another part of SFT's role was to support the Scottish Government Health Directorate (**SGHD**) at the portfolio level. In respect of the OBC, this involved providing input on NPD-specific elements to the Scottish Government's evaluation of the OBC.

Mike Baxter (Deputy Director (Capital and Facilities), Directorate for Health, Finance and Information Scottish Government Health Directorate and the then chair of CIG), prepared a paper entitled, "*Scottish Government Governance arrangements for Royal Hospital for Sick Children / Department of Clinical Neurosciences (RHSC/DCN) – Outline Business Case*" dated 7 October 2011 (Bundle 7, doc 13, p.455). That paper set out the arrangements within Scottish Government for the evaluation of the OBC that was, at that time, being prepared for the Project and set out the interface with other organisations, including SFT, in that process. This document confirmed that SFT's response to the OBC would, in addition to feeding into the design review process, also cover the areas within SFT's remit within the context of both the 22 March 2011 and 1 June 2011 letters, noted at paragraphs 40 and 20 respectively. The design review process formed part of the OBC process in order to validate the capex cost of the Project which would be funded by Scottish Government.

24. Donna Stevenson (then Associate Director, now Senior Associate Director, of SFT) provided comments and appraisal on the OBC. This included the preparation of a list of issues (Bundle 7, doc 16, p.480) to be covered in SFT's comments on the OBC, which confirmed what SFT would do as part of the evaluation process.

25. Donna Stevenson also prepared a letter to be sent to Mike Baxter, in relation to the Project's OBC, ahead of the CIG's meeting of 31 January 2012 (Bundle 7, doc 19, p.493) (This letter contained SFT's comments and issues requiring clarification in relation to the OBC as submitted by NHS Lothian to SGHD on 22 December 2011).

26. That letter was circulated in draft to me on 24 January 2012, together with a paper entitled "*NHS Lothian, RHSC/DCN Project Outline Business Case Comments and Issues for Clarification*" (Bundle 7, doc 15, p.475). The letter set out SFT's comments and recommendations on the OBC. The accompanying note set out the comments and issues for clarification by NHS Lothian on the OBC.

27. The issues raised as part of that note fall under the following headings; (i) Negotiations with Consort; (ii) Project Review; (iii) Governance; (iv) Resourcing; (v) Unitary Charge; (vi) Letters of Support; (vii) Planning Permission in Principle; and (viii) Market Interest.

28. A member of SFT's staff, Colin Proctor, sat as a member of CIG, which led on the evaluation of the OBC on behalf of Scottish Ministers, and he fed his comments into the CIG evaluation process.

29. On 16 January 2012, Colin Proctor (as a member of CIG) provided comments on the OBC to Mike Baxter, SGHD by email (Bundle 7, doc 17, p.482). He attached a paper with NHS Lothian's comments and clarification requests in relation to the OBC, together with an updated action plan relating to SFT's project review, provided as Appendix 2 of the OBC (Bundle 7, doc 12 p.441). He also confirmed within that email that Donna Stevenson would be in touch to discuss SFT's written response commenting on the OBC, with particular reference to the draft 'Funding Conditions' in relation to the provision of revenue support for health NPD projects.

30. Donna Stevenson's input included liaising with Iain Graham (Bundle 7, doc 18 p.483), Director of Capital Planning and Projects at NHS Lothian, on a number of clarification points in relation to the OBC and liaising with both Kenneth Ngai, whose role at NHS Lothian I cannot recall, and Brian Currie, Project Director, at NHS Lothian.

31. On 8 March 2012, Donna Stevenson provided Brian Currie with an update in relation to the various clarification issues and noted where, in her view, there were no further updates required prior to OBC approval (Bundle 7, doc 23 p.534). On 9 February 2012,

she also provided Mike Baxter with a paper containing SFT's comments on NHS Lothian's comments and clarification requests in relation to the OBC (Bundle 7, docs 20 & 21, pp.515 & 520) .

iii) OBC Approval

32. SFT had no role in the approval of the OBC. The OBC required to be approved by both NHS Lothian prior to its submission, and ultimately the Scottish Ministers, to enable the project to proceed to the procurement stage.

33. I was asked whether or not I considered the business case process to be a collaborative process. The business case process can be described as collaborative, in the sense that each of the parties involved in the business case process (its preparation, appraisal and approval) was working with the others with the common purpose of progressing the Project. However, in my view, a collaborative activity involves the parties having a common interest and working hand-in hand on the specific task in which they are engaged, for example drafting a section of the business case or evaluating the case. In that way, I view NHS Lothian and its advisors as collaborating on the production of the business case, and SFT collaborating with Scottish Government on its appraisal. Scottish Ministers were responsible for approval of the OBC. However, as I have described, there was a close working relationship between SFT and the other parties, certainly with regards to NPD-specific elements of the OBC.

Individuals from SFT involved in development of OBC

34. At one stage during the project, Gordon Shirreff, a SFT employee, was briefly informally seconded to NHS Lothian on a part-time basis (in or around June 2011) to provide an additional resource with PPP procurement experience to NHS Lothian's team. Whilst on that secondment, he provided input as a member of the project team to the development of the OBC.

35. Gordon Shirreff acted under the direction of Brian Currie during the period of his informal secondment and any contributions provided by him to the management and administration of the project, in whatever form, were not in any way to be taken as the SFT view. This was acknowledged by Brian Currie of NHS Lothian in his email to Andrew Bruce, SFT, dated 24 June 2011 (Bundle 3, vol.2, doc 48, p.422). Gordon Shirreff was a member of the "*RHSC + DCN - Little France: Business Case Working Group*", during the short period whilst he was on informal secondment.

36. The SFT input into NHS Lothian's development of the OBC was carried out principally by Andrew Bruce and supported by Donna Stevenson. Andrew provided the financing assumptions for the shadow bid model as described at paragraph 21 above.

Overview of KSR process

37. At the time that the Project was procured, it was a condition of Scottish Government funding support that all projects in the NPD Programme were, in addition to any existing project approvals processes, externally validated by SFT. This was set out in the letter from the Scottish Government to NHS Board Chief Executives dated 22 March 2011 (Bundle 3, vol.2, doc 43(i), p.377).

38. SFT undertook that validation by carrying out KSRs of projects at key stages of the procurement. Please see document entitled, "*Validation of Revenue Funded Projects: The Key Stage Review Process Information Note to Projects*" dated December 2011. (Bundle 3, vol.2, doc 58, p.650) The KSR process was designed to support the successful delivery of revenue funded projects by providing an assessment of the readiness and application of best practice (including SFT Value for Money (**VfM**) guidance) of projects before they moved onto the next stage in the procurement process.

39. The KSR process was a tool for assessing a project's readiness to commence and

proceed through the various stages of procurement. It was also used to periodically verify compliance with or satisfaction of the conditions of Scottish Government revenue funding support, as contained in the OBC approval or funding award letter.

40. In the letter from the Scottish Government to the NHS Board Chief Executives dated 22 March 2011 titled, "*Scottish Government Funding Conditions for Delivering Projects Through the Non-Profit Distributing Model*", (Bundle 3, vol.2, doc 43(i), p.377), the NPD model is explained. Under the heading, "*Project Assurance*" it states:

"*Both the procuring body and the Scottish Government require assurance about the robustness of project management and the prospects for successful procurement, delivery and operating Key Stage Review provides a structured, independent "due diligence" review of projects, supporting Project Managers and Sponsors at commercially critical procurement stages. Key Stage Reviews help to ensure that procuring authorities are sufficiently advanced in their project development and have put in the place the necessary delivery arrangements and documentation in order to secure high quality sustainable bids. They also ensure that authorities are adequately resourced to effectively and efficiently carry out the procurement, construction and operational stages of the projects. Key Stage Reviews are a formal requirement for all projects delivered through the NPD model and will be conducted by SFT*."

41. For NPD projects, the KSR process involved reviews at the following stages:

(i) Pre-issue of Official Journal of the European Union (**OJEU**) notice;

(ii) Pre-issue of Invitation to Participate in Dialogue (**ITPD**);

(iii) Pre-Close of Dialogue;

(iv) Pre-Preferred Bidder Appointment; and

(v) Pre-Financial Close

These were carried out by SFT in relation to the Project as follows:

Key Milestone	KSR	Date	Second Reviewer
Issue of OJEU Notice	Pre-OJEU Key Stage Review NPD KSR1 – Pre-OJEU	4 December 2012	Tony Rose
Issue of Invitation to Participate in Dialogue	Pre-ITPD Key Stage Review – Pre-ITPD KSR	7 March 2013	Tony Rose
Close of Dialogue	Pre- Close of Dialogue Key Stage Review NPD KSR 2 – Pre-CoD	11 December 2013	Tony Rose
Preferred Bidder Appointment	Pre-Preferred Bidder Appointment Key Stage Review	28 February 2014	Tony Rose
Financial Close	Pre-Financial Close Key Stage Review NPD KSR 4– Pre FC	11 February 2015	Colin Proctor

42. Each review was an assessment of whether the project was suitably developed in terms of "Project Readiness"; "Affordability"; "Value for Money"; and "Commercial robustness".

43. The KSRs were carried out at no cost to the procuring authority by the member of the SFT team who normally provided support to the Project (**Reviewer**).

44. The KSR process involved the assessment of the readiness of projects against a pro-forma list of questions at each key stage of the procurement. In the run up to each review point, the Reviewer considered the status of the Project against the relevant pro-forma list on the basis of information obtained in his/her day to day dealings with the project and sought, where required, contributions from the project team to allow completion of the list and prepare a written draft report with comments and recommendations.

45. The process of undertaking the KSR was designed to be the right balance of providing external assurance and minimising imposition on the project team to provide the evidence for the review. These sorts of reviews had been undertaken previously in PPP-type projects, where it had been the responsibility of the procuring authorities to complete a lot of the paperwork which provided evidence to the reviewers. SFT was trying to make that a lighter touch activity for the procuring authorities by requiring the SFT team member with the greatest knowledge of the Project to gather evidence from the project team and to complete the documentation alongside the procuring authority. The review was then done separately by a senior member of the SFT team who had not been involved in the Project (**Second Reviewer**). The alternative to that approach would have been to require the project team to collate evidence and complete the KSR documentation and it would then have gone to someone who was not involved in the project to review it. That would have placed more demand on time and resources of the project team who, in the best interests of the project, I thought were best dedicated to continuing to do their work rather than to complete KSR documentation.

46. Although there was no formal submission required from the procuring authority, the project team was required to provide the Reviewer with information to allow him/her to complete the list and compile his/her report. The Reviewer could also ask the project manager to specifically confirm certain points or that there were no outstanding issues that would impede the progress of the project to the next stage of the procurement process.

47. The Reviewer also prepared a short report and made recommendations as to whether in his or her view the Project was ready to proceed to the next stage of procurement and what actions were required to achieve the appropriate state of readiness either to proceed to the next stage or in advance of the next review.

48. Once completed by the Reviewer the draft report was scrutinised by a member of SFT's senior management team as Second Reviewer before being issued to the relevant Project Sponsor / Scottish Government and copied to the procuring authority. The relevant Project Sponsor and/or Scottish Government would, as part of its overall sign-off, determine whether and on what basis the Project should proceed to the next stage taking into consideration any recommendations made in the KSR report.

49. The precise timeframe for completing the review and submission of SFT's report was prepared with the Project Sponsor and/or Scottish Government to integrate with other project approvals processes.

50. The Reviewer for each of the 5 KSRs for the Project was Donna Stevenson. The Second Reviewer for each of the KSRs is noted in the table provided above at paragraph 41, being either Tony Rose, Director or Colin Proctor, Director.

51. The Second Reviewer was a senior member of the SFT management team who did not have a direct role in supporting the Project during the procurement. Their role was to review and challenge the contents of each KSR and sign it off before it was issued.

52. The dates of each of the 5 KSRs for the Project are noted in the table provided above at paragraph 41.

53. In summary, the key finding from each KSR was that the Project was ready to proceed to the next stage of the procurement, subject to the recommendations noted, which

required to be addressed by the Project Team within the timescales specified.

Site constraints and contractual dispute with Consort

54. SFT was not involved in identifying the site for the Project. The decision had already been made to build the RHCYP at Little France and NHS Lothian had already decided that the Project interacted with the redline boundary of the existing RIE hospital. It was clear from the Project Dashboard Report dated 12 November 2010 (Bundle 3, vol.1, doc 27, p.1102) that the issue of interface with the RIE project had been identified before the Project was included in the NPD programme, but SFT is not aware of when this identification occurred.

55. On 8th December 2010, immediately following the announcement that the Project was to be part of the NPD programme, SFT sent a letter to Iain Graham, (Bundle 3, vol.2, doc 31, p.108), which stated:

"*Interface with Existing PFI Contract*

We agreed that SFT would start to assemble some of the key issues associated with Consort and the existing PFI contract, for further discussion with the Health Board. We understand these to include resolution of a car park land swap, the potential removal of soft services from the contract, decisions with regard to any potential time extension to the contract and any reconfiguration of the contract required to accommodate the Project. All of these issues potentially do not require to be resolved ahead of the start of the procurement of the new contract, but as discussed, we firmly believe that the land swap does require early resolution and a full agreement with Consort should be pursued as a matter of priority. Proceeding to a procurement of the Project without full Health Board control of the land required could compromise the procurement, especially given the role of Consort as a potential bidder for the Project".

56. Given that the hospital was to be sited within the confines of land that had already been leased to a PFI contractor under the RIE's PFI contract, it was the view of SFT that NHS Lothian had to procure the necessary rights to enable the development of the RHCYP / DCN within that site, to connect into the existing RIE hospital and for all enabling works to be carried out before proceeding to procurement. This was to allow for open competition in the Project and to ensure there were no hold-ups either during or after procurement. Not least because the funders of the existing PFI Contract required to give their consent to a variation to that contract and the potential compromise to the procurement given the role of Consort, the PFI Contractor under the existing RIE PFI Contract, as a potential bidder for the project.

57. Whilst SFT did provide NHS Lothian with assistance with the development of a strategy to deal with Consort about the variation, the approach and negotiation were for NHS Lothian, which I believe were carried out by Susan Goldsmith. (Bundle 3, vol.1, doc 28(i), p.1111)

58. SFT advised NHS Lothian that the issues with the site should be resolved with the PFI Contractor, Consort, prior to the Project launching to procurement. The Scottish Government also advised NHS Lothian that the OBC could not be considered until the land transaction was concluded. (Bundle 3, vol.2, doc 39, p.354)

59. Ultimately, the procurement was launched prior to the issues being resolved on the condition that they would be resolved prior to the ITPD stage on the basis that giving clarity to the market that this would be the case would manage the impact on bidder confidence discussed above. The Pre-OJEU KSR confirmed that NHS Lothian should finalise the Supplemental Agreement for signing by NHS Lothian and Consort during December 2012.

60. It is my recollection that the Supplemental Agreement (**SA6)** negotiated between NHS Lothian and Consort (and its funders) reflecting all the amendments required to the

existing PFI Contract was signed prior to the issue of the ITPD. NHS Lothian should be able to confirm this.

61. The SA6 was a contract variation to the RIE PFI Contract which was required to enable the land to be released, enabling works to be completed and connection to be made to the building, to allow the Project to proceed. Whilst there were prolonged discussions and negotiations around the terms of SA6, including with the funders (as their consent was required), I was not aware of there being a formal dispute requiring resolution under the dispute resolution procedure within the existing RIE PFI Contract.

62. For clarity, the decision to build on the Little France site was made independent of the funding route. Accordingly, the necessary rights to the land required to be obtained regardless of the funding route.

63. I do not recall whether or not the time it took to negotiate the variation was ever on the critical path for the NPD delivery route programme, as the activity was undertaken in parallel with other project development and procurement activities, including the development of the reference design and the pre-qualification stage as noted above. It was certainly one of the time- critical activities being undertaken at that time.

64. Separately, the Project Dashboard Report dated 12 November 2010 (Bundle 3, vol.1, doc 27, p 1,104) suggests that the activity may have been on the critical path for the delivery of the RHCYP as a capital project, which was in development prior to November 2010. Reviewing that document, which I do not believe I have seen previously (prior to it being provided to me in Inquiry documentation), suggests that if all other activities under that delivery route had progressed as planned, resolving the SA6 with Consort would have led to a delay from the programme in place at that time. Negotiating the SA6 with Consort required substantial internal resource from NHS Lothian and input from its advisors. I cannot not say whether there was a wider cost impact on the Project.

65. I supported the negotiations with Consort's funders, whose consent was required in accordance with the RIE PFI Contract, in order for any variation to be effected. I know that, at one stage, I wrote a letter to at least one of the funders to try to assist to resolve this and I think I had conversations with at least one of the funders, but I do not recall any more than that. My colleague, Donna Stevenson, gave guidance with regard to the discussions with NHS Lothian and Consort, and also provided commercial support on the variations required to the existing RIE PFI Contract.

66. I have been asked if the Project was particularly complex. I believe any project to build an acute hospital is a particularly complex project. In my experience there are a number of factors which contribute to the complexity of a project including:

(i) Scale: – the scale of a project (generally measured as capital cost) affects its complexity, as larger projects require a greater volume of activity at all stages to be effectively coordinated. As a capital project, this Project was larger than most, but was not the largest acute hospital project in the NPD programme, and in other sectors, such as roads, there were other projects in the programme which were larger by some margin.

(ii) Sector: – some building sectors are generally accepted to imply more technical complexity than others. My view is that healthcare buildings are generally more technically complex than education buildings, which was the other main sub-sector of buildings in the NPD programme, and there are different but similarly significant complicating factors in roads projects.

(iii) Stakeholders: – the internal and external stakeholder environment in the procuring organisation affects complexity. In this case, NHS Lothian was a single and stable procuring organisation within a well-established overall set of organisational arrangements – the NHS – so not particularly complex. Internally, the stakeholder complexity would come from the number of clinical specialities to be dealt with. The Project was for a children's hospital and DCN

rather than a general hospital, with a wide range of specialities meaning, I expect, that less interaction across different specialities and departments would have been required compared to some other healthcare projects.

(iv) Regulatory environment: - undertaking a project subject to external regulation adds complexity as there is a third party undertaking scrutiny and often providing opinion at key stages. Whilst the Project was delivered with the sector-specific standards and guidance, there was no external regulatory involvement.

(v) Location, Land and site constraints: – by the time of SFT's involvement, it had been decided to deliver the Project at Little France. As such, there was no need for a site search or acquisition of land in the market, which avoided a significant complexity faced by some projects. The Project was also undertaken on a single site which avoided the multiplication of issues across sites which adds complexity to some projects and was in a reasonably accessible location removing some logistic complexities. There was, however, a known interface with the RIE site and a relatively constrained operational site on which to deliver the Project, which added complexity.

(vi) Physical Interfaces: - the Project had a physical interface with the existing RIE building which added complexity compared to many other building projects, but did not present as many interfaces as say a roads project which requires linking into a wider network.

(vii) Planning: - I was not involved in town planning issues for the Project, but as it was delivered on a single site, which was already in use as a hospital by NHS Lothian, that does not seem to suggest comparative complexity with other projects.

(viii) Utilities: - in some projects, clearing utilities from the site, or getting required utilities to the site present very significant enabling projects in their own rights.

I was not close to the detail of utilities issues on the Project but was not aware of any that would be considered particularly out of the ordinary or complex.

(ix) Ground Conditions: - the ground conditions at the site can create additional complexity and I was not close to the detail of whether the Project faced any unusual complexity in that regard.

(x) Funding / commercial arrangements: - NPD and other forms of PPP funding arrangement involve contracting for a 25-30 year life cycle of an asset and for the provision of finance. This adds complexity to the technical work streams as the requirements for services over the life cycle require to be defined along with the requirements for the building itself. The legal and financial work streams are more complex as the NPD Project Agreement and associated documentation is more extensive than for a capital procurement and a financial model for the asset life cycle is required.

67. Overall, the Project was a major and complex project. It had a number of features that I felt generally added complexity, and every project has a unique combination of those characteristics. However, I did not consider that overall it was "particularly" complex.

68. As stated, the NPD structure did add complexity, but it was probably the simplest of a number of the options which were considered by NHS Lothian, given that the project was no longer able to be capitally funded. The options that NHS Lothian considered were summarised within paragraph 3 of the letter from SFT to Iain Graham of NHS Lothian dated 8 December 2010 (Bundle 3, vol.2, doc 31, p.109), as follows:

"Procurement Options

We discussed a number of options when we met:

3.1. Susan confirmed at the meeting that a capital funded route is not an option, given budgetary pressures.

3.2. For the reasons we discussed (e.g. scope of the existing procurement and the nature of the project) incorporating the project within the South East hub is not an option.

3.3. You mentioned the possibility of retaining the existing PSCP for construction (with a revised scope to include the DCN), NHSL providing the lifecycle and ongoing maintenance and seeking to procure financing through an SPV (Option 6). As we said at the meeting, in order for the project not to be classified as a government asset (and hence count against the Scottish Government's capital budget) the requirements of European System of Accounts (ESA 95) need to be met. In short this involves the transfer of construction and one of demand or availability risk to the private sector. We do not see how this proposal would meet those tests, though if you wish to pursue this option we suggest that you take advice from your financial advisor.

3.4. Another proposed option was the retention of the existing PSCP for construction (with a revised scope to include the DCN) and the introduction of finance (Option 3) or finance and maintenance/operation (Option 4). We discussed this briefly and ruled both options out given the scope of the original OJEU for the Health Framework.

3.5. A further option concerned the retention of the existing PSCP for construction (with a revised scope to include the DCN) which you suggested would involve the PSCP being novated to an SPV which would contract with NHSL to provide the NPD DBFM solution (Option 5). In the first instance we agreed that NHSL would seek advice as to whether it would be legally possible and we attach at Annex 2, for discussion, our suggested questions for your legal advisers in that regard. Given the differences in the underlying construction contracts envisaged in the Health Framework and within an NPD contract structure, our strong view

is that a further party would need to be introduced who would take on the risks associated with a D&B contract required for the NPD procurement and subcontract with the PSCP for the Health Framework construction contract (i.e. 'wrap' the Health Framework contract). Beyond the legal issues associated, we believe this could cause commercial issues in receiving strong value for money proposals from the private sector. We would be happy to discuss this further if appropriate.

3.6. There is the option of concluding the existing PSCP arrangements and tendering the RHSC/DCN project using a traditional NPD DBFM procurement route. (Option 1) In that case NHSL could provide bidders with an exemplar design to show the adjacencies etc which it has worked through internally including with clinicians to date. NHSL will want to be satisfied from its legal advisers that, as was indicated yesterday, the existing framework arrangements can be concluded without penalty, except for payment for work to date.

3.7. As discussed yesterday, Option 1 appears the most likely route, but the other options need to be further considered further, in consultation with legal advisers along with any options not currently listed. As discussed, this needs to be done as a matter of urgency such that a recommendation can be made to a Committee Meeting on 12th January 2011."

69. The options put forward by NHS Lothian were hybrid funding models, which were more complicated than the NPD model. The NPD model had been used previously and was familiar to the market. NPD shared similar characteristics to other PPP approaches. Paragraph 5.1 of SFT's document titled "*Revenue Financing Opportunities for Infrastructure Investment*" (Bundle 3, vol.1, doc 25, p.1,082 states);

"Scotland has a long and successful history in the delivery of PPP healthcare projects, including acute; community; mental health and ACADs, 31 in total."

70. There was an active and mature market for PPP healthcare and the NPD structure had been market tested in health via the Tayside Mental Health Development Project; and deliverability had been previously demonstrated for the wider PPP healthcare projects in Scotland.

Switch to NPD Model

71. A large part of the scope of what latterly became the Project, formerly the Royal Hospital for Sick Children, was under development as a capital project. It is my understanding that the Department for Clinical Neurosciences was under consideration as a separate capital project and others will be better placed to answer what its position in the capital programme was at that time.

72. I have been asked to explain why the change was made from a capital funded project to the NPD model and the driving factors behind the decision. The change was made in the context of the funding position at the time, as set out in Scotland's Spending Plans and Draft Budget 2011-2012 published by the Scottish Government in November 2010 ("**Draft Budget**"). (Bundle 7, doc 2 pp.55&89)That Draft Budget stated that:

"This is a Budget set against the most dramatic reduction in public spending imposed on Scotland by any UK Government. The Comprehensive Spending Review confirmed that the Scottish Budget will be cut by £1.3 billion next year compared to this. Within that, Scotland's revenue budget has been cut by more than £500 million and our capital budget, which is so vital to our efforts to support economic recovery, has been cut by around £800 million (or about 24 per cent in cash terms)."

It goes on to state that:

"[the] Budget also takes steps to leverage additional private sector investment to maintain levels of aggregate investment in the Scottish economy. In the absence of borrowing powers, the Scottish Government will work with the Scottish Futures Trust and local authorities to generate additional funding to support higher levels of capital investment than would be possible through the capital budget alone. In addition to the planned capital investments in 2011-12 and future years, the Scottish Government will use all available levers to: take forward a new pipeline of revenue financed investment, worth up to £2.5 billion, to be delivered through the Non Profit Distribution (NPD) model".

73. In the context of the July 2010 Independent Budget Review Group report (para 4 and 5) and the October 2010 UK Spending Review (para 70), SFT assisted the Scottish Government to identify priority projects which were suitable for procurement using the NPD revenue funded model. SFT provided potential options to the Scottish Government for revenue financed investment to deliver "*additionality*" over the capital budgets in October 2010 prior to the publication of the Draft Budget on 17 November 2010.

74. The "*CSR Options – Revenue Financed Investment*" document was drafted on or around 13 October 2010. (Bundle 3, vol.1, doc 24, p.1075). The "*Revenue Financing Opportunities for Infrastructure Investment*" document (Bundle 3, vol.1, doc 25, p.1,082) was provided to Scottish Ministers on 20 October 2010 which, amongst other sectors and projects, suggested four health capital plan projects that could be potentially suitable for revenue funding, which included the Project.

75. I assume that the Scottish Government's Capital and Risk division provided advice to Scottish Ministers relative to the change of the funding basis of the Project. I do not know whether any other party provided advice to the Scottish Ministers regarding this decision.

76. Each of the projects and programmes considered by SFT, including the Project, were evaluated at pace against a set of suitability criteria in assessing whether they were suitable for procurement under the NPD model. These criteria are reflected within

Appendix A of the Value for Money Assessment Guidance: Capital Programmes and Projects dated October 2011 (Bundle 7, doc 11 p.353) :

"

- *a major capital investment programme, requiring effective management of risks associated with construction and delivery;*
- *the private sector has the expertise to deliver and there is good reason to think it will offer value for money;*
- *there is significant constraint upon capital budget availability at either Government or Directorate level;*
- *proven track record in delivery;*
- *the structure of the service is appropriate, allowing the public sector to define its needs as service outputs;*
- *the nature of the assets and services identified as part of the projects are capable of being costed on a whole-of-life, long term basis;*
- *the value of the projects/programme is sufficiently large to ensure that procurement costs are not disproportionate;*
- *the technology and other aspects of the sector are stable, and not susceptible to fast paced change;*
- *planning horizons are long terms, with assets intended to be used over long periods into the future; and*
- *there are robust incentives on the private sector to perform."*

77. The NPD model had previously been used on the £95 million Tayside Mental Health Development Project, the first non-education PPP procured under the NPD model, which reached financial close in June 2010. SFT advised in the "*NPD – Way Forward*" document (Bundle 3, vol.1, doc 28(i), p.1,111) that the NPD project documentation had been used in the health sector at Tayside and that there should be consideration of any lessons learned from that use.

78. The NPD model is, in many ways, similar to other forms of revenue funded PPP projects of which there had been 31 in total at that time (including acute hospitals, community hospitals, mental health and ACADs). NHS Lothian was familiar with those other forms of PPP projects, including NHS Lothian's use of the Private Finance Initiative in respect of the design, build, finance and operation of the RIE PFI Project. The critical differences in NPD in comparison to other forms of PPP do not materially affect the specification of technical requirements (with which they will have been familiar given the RIE PFI).

79. As stated above, the private sector had proven expertise and track record in PPP and other NPD projects to deliver health projects and there was already an established portfolio of revenue-funded health projects in Scotland. In reviewing the suitability of the Project for the NPD model, SFT concluded that the Project met the criteria and was, therefore, suitable for procurement under the NPD model.

80. The decision that the Project should be included in the NPD programme was taken by the Scottish Ministers as part of Scotland's Spending Plans and Draft Budget. That document names the Royal Sick Children's Hospital and Department of Clinical Neurosciences in Edinburgh (c.£250 million) as one of the projects in the new pipeline of NPD investments to help support key projects across core public services. That document states that the "*new pipeline of NPD projects is being targeted to provide the maximum support for the wider capital programme and for Scotland's key public service*". It goes on to state: "*We will also ensure the delivery of a range of other health projects, including the Royal Sick Children's Hospital and Department of Clinical Neurosciences in Edinburgh through the NPD approach*."

81. Due to this unprecedented and significant cut in capital budgets, not all planned capitally funded projects would have been able to go ahead. It is far from clear whether the RHCYP project would have been able to go ahead as a capital funded project, far less the DCN, which was at an earlier stage of development.

82. The capital constraints were recognised by NHS Lothian, along with the fact that the Project could not go ahead under capital procurement. Susan Goldsmith (Director of Finance) acknowledged that at a meeting which SFT and NHS Lothian attended in early December 2010, as reflected within paragraph 3.1 of the letter from SFT to Iain Graham dated 8 December 2010, (Bundle 3, vol.2, doc 31, p.109), which stated: "*Susan confirmed at the meeting that a capital funded route is not an option, given budgetary pressures*".

83. NHS Lothian briefly considered a number of alternative suggestions but was aware that capital funding route was not an option, given budgetary pressures. For the reasons stated within the letter from SFT to Iain Graham dated 8 December 2010, referred to above at paragraph 68, it was considered that Option 1 (the NPD route) was the most likely route but that NHS Lothian should consult with their legal advisers on all of the routes discussed and any other potential routes as a matter of urgency so that a recommendation could be made to the Committee meeting on 12 January 2011.

84. The use of the NPD model as the only available option was also stressed by John Matheson, Head of Health Finance at the Scottish Government, at a meeting on 12 July 2011 attended by NHS Lothian, SGHD and SFT (Bundle 3, vol.2, doc 50, 434).

85. NHS Lothian noted at the meeting on 12 January 2011 (Bundle 3, vol.2, doc 34(i), p.315) that NPD had previously been used in the health sector in the Tayside Mental Health NPD project and the minute confirmed that "*dialogue was already underway with colleagues in NHS Tayside, in particular to highlight any lessons learned*".

86. I have been asked if NHS Lothian was consulted about the switch to NPD prior to decision being made. I do not have any recollection of SFT consulting with NHS Lothian in relation to this decision. SFT's advice to government was part of confidential advice in relation to a pre-budget consideration which stated that "*The paper is the work of Scottish Futures Trust alone and presents our views. It gives a high level view of opportunities from our perspective and does not include assessment of deliverability from*

officials with portfolio responsibilities'. (Bundle 3, vol.1, doc 25, p.1077) I do not know whether Scottish Government consulted with NHS Lothian.

87. I have been asked why NHS Lothian were not consulted on the switch to NPD and if this was unusual. As stated in paragraph 86 above, SFT did not consult with any of the projects which it identified as suitable for NPD, as we were working confidentially with the Scottish Government in relation to the development of the Draft Budget and were required to confirm to the Scottish Government what projects (across a range of sectors) may be suitable for delivery using the NPD model.

88. SFT was required to provide the Scottish Government with a rapid assessment and in that context, it was not possible for SFT to consult with all of the potential projects stated as being suitable regarding their potential to be taken forward as a revenue funded investment. I do not know whether Scottish Government consulted with NHS Lothian. If it was not discussed, then in a different set of circumstances, with more time available, I would perhaps have expected it to have been discussed with NHS Lothian by the Scottish Government prior to the announcement of the switch to NPD, although the processes around the confidentiality of budget announcements are a matter for Scottish Government.

89. At the time of the switch to NPD funding, the Project was re-scoped to include the DCN to deliver an integrated facility incorporating both the RHCYP and the DCN in one building to meet NHS Lothian's clinical requirements. (Bundle 3, vol.2, doc 31, p.108)

90. I have been asked, following the switch to NPD model, who was responsible for the decision to reincorporate the DCN. Whilst SFT identified within the "*Revenue Financing Opportunities for Infrastructure Investment*" document (Bundle 3, vol.1, doc 25, p.1,077) provided to Scottish Ministers on 20 October 2010, that it would seem appropriate to combine the RHCYP and DCN projects at the ERI site and to procure this as an individual NPD project, it was not SFT's decision whether or not the DCN should be incorporated into the Project.

91. SFT's letter to Iain Graham at NHS Lothian dated 8 December 2010, (Bundle 3, vol.2, doc 31, p.109), confirmed that NHS Lothian's preferred option for meeting its clinical requirements was an integrated facility incorporating both the RHCYP and the DCN in one building. In the minute of an NHS Lothian meeting on 12 January 2011 (Bundle 3, vol.2, doc 34(i), p.316) it stated that:

"*The Business Case for the DCN development, approved by the Board in the November 2009 recommended the preferred and best clinical option as a combined build with RHSC. This has been reaffirmed by the outcome of a non-financial benefits appraisal undertaken on 16th* December 2010".

92. This was also later noted by the Infrastructure Investment Board (**IIB**) at their meeting on 26 September 2011 (Bundle 3, vol.2, doc 54, p.484):

"the integrated project allows the generation of a number of physical and operational synergies that would not have been possible had the developments been taken forward separately (e.g. the ability to deliver paediatric and adult neurosurgery in the same theatre suite)".

93. I assumed that the decision was welcomed by NHS Lothian as the integration of the DCN was a preferred option put forward by them.

94. The switch to NPD funding also required a change in procurement approach for the Project. NHS Lothian had available frameworks for the delivery of capital projects, and I understand that they were utilising one of those frameworks to deliver the project as a capital build, or elements of what turned out to be the RHCYP project as a capital project. However, procurement of an NPD Project was not covered by these frameworks. It is not the custom and practice to procure NPD-type projects or other PPP-type projects, of that scale through framework arrangements. When the project switched to NPD, it had

to use the procurement route that is appropriate for NPD projects, which had previously been the 'negotiated procedure' under the European procurement directives. The 'competitive dialogue' procedure was introduced in 2006 and was regarded as the appropriate procurement route to procure a standalone NPD project of that scale.

95. Frameworks tend to be set up for types of procurement where an organisation or organisations are going to be buying multiple products / items that are broadly similar over a long period of time. Accordingly, every time you are looking for something new, you do not have to go to the whole market - you have a framework of people/firms and you can deal directly with those. If you are going to be buying broadly similar products / items over a three or four-year period of time, then it makes more sense for efficiency and effectiveness to pre-select a group of those people/firms within your framework. The drawback to this option is that you do not get access to everything that the whole market potentially has to offer for each and every project.

96. There were 10 NPD projects in the programme at the time. The nature of these projects was varied, for example, some were colleges, some were hospitals and some were roads. It is a different market for each of these different types of project. There are also different layers to NPD project provision, such as the facilities management, the contractor who will build it, and the special purpose company which will provide the equity and bring it all together. Ultimately, open procurement, through the EU competitive dialogue processes for each individual project in the programme, was considered to be the best way to deliver value for money.

97. I have been asked if the switch to NPD model resulted in delays to the Project. There was insufficient capital to complete the capital project at that time. I am unable to speculate as to if, or when, further capital would have become available and therefore when, or if, that project could have ever actually been completed due to the capital constraints. The switch to the NPD model gave the project a route to completion.

98. As noted at that time, there were still land issues that needed to be resolved between NHS Lothian and the PFI Contractor under the RIE PFI Project Agreement, regardless of the funding and procurement model.

99. Noting the substantial uncertainty around the delivery programme for the RHCYP project as a capital project, it was the case that the change in scope of the project discussed in paragraph 89 above and the change in procurement route, including the preparation of the reference design for the revised project scope discussed took time. The switch to NPD, therefore, led to a later completion date than that which was programmed for the RHCYP project as a capital project at the time of the switch.

100. I have been asked if the switch to NPD model resulted in increased costs for the Project. The scope of the Project changed with the inclusion of the DCN and so there would have been an increased cost. In addition, there were advisory costs associated with NPD procurement which in my experience are generally higher than advisory costs under capital procurement. There was an additional cost of financing the Project as a result of the NPD funding route and NPD includes costs for the whole lifecycle of the building including facilities management service. Setting the cost of finance, life-cycle and advisory element aside, it is not possible to say whether there were any “increased costs” in the capital build cost element of the project given that the scope changed.

101. I have been asked if the existing design work which had been completed by BAM was retained following the switch to NPD model. It is my understanding that elements were retained and taken forward as the reference design. This was a decision taken by NHS Lothian. This decision was addressed at NHS Lothian's Finance and Review Committee Meeting on 12 January 2011 (Bundle 3, vol.2, doc 35, p.323).

102. The committee was invited to "*Approve the continuation of Stage 3 of the BAM contract, under Frameworks Scotland, to develop the reference design for the joint facility for the Royal Hospital for Sick Children and Department of Clinical Neurosciences"*.

103. In a later meeting of the RHCYP / DCN Project Working Group (Bundle 7, doc 5 p.283, Brian Currie advised that "*NHSL is making progress re the reference design. BAM had stated that using their existing design team to produce the reference design might preclude BAM from being a bidder. MacRoberts has advised that as long as the design team's work is strictly limited to the reference design this will not be an issue*." I understand that MacRoberts were legal advisers to NHS Lothian.

104. It was my understanding that NHS Lothian was keen to avoid losing the work that had been carried out to date on the capital project development by BAM and its design sub-contractors and to avoid any delay associated with re-procuring a separate design team.

105. I have been asked if the NPD model is still used for public sector capital projects. The NPD model is no longer used. It was developed to deliver additionality of capital investment capacity, i.e. in any year to deliver a value of new projects greater than the Scottish Government's overall capital budget. This additionality depends on the project being classified to the private sector under national accounting rules which followed European statistical guidelines. This meant that the Project could be paid for from revenue budgets over the 25-year life of the NPD contract, rather than capital budgets in the years in which it was built. These rules were set by Eurostat and changed from "ESA95" to "ESA10" in 2014. Following a detailed analysis of one of the NPD projects, Eurostat ruled that NPD projects should be classified to the public sector, meaning that capital budget would be required in the years in which they were built and they would, therefore, not meet the objective of delivering additional capital investment. No new projects were added to the NPD programme following that decision.

<u>Reference Design</u>

106. I have been asked to explain my understanding of the difference between an exemplar design and a reference design. I do not believe there to be prescriptive definitions of exemplar design and reference design, however in the context of the Project, I understand the term reference design was used to signify a more detailed stage in design development

than an exemplar design. The definition and the meaning that should be attached to those words will depend upon the status and definition they are given in the context of the whole procurement process and in the ITPD for any particular project.

107. In the context of the Project, it is noted from an extract of a draft NHS Lothian Committee paper from around February 2011 (Bundle 3, vol.2, doc 42, p.374) that there is a comparison table of the issues being considered comparing a traditional PPP procurement with a reference design approach. That table notes:

Traditional PPP procurement	**Reference Design**
Exemplar design undertaken by Board's technical advisers to Stage C – Concept Design	Detailed design work to Stage D – Design Development (or even into Stage E – Technical design).

108. On reading the above table, I agree with the premise that the level of pre-procurement design under the reference design approach was more detailed than had been the norm for previous generations of PPP building procurement.

109. SFT promoted the adoption of the reference design believing that it would reduce procurement timescales and procurement costs, particularly for bidders as it would reduce the need for multiple designs to be produced by multiple bidders during the bid period. It would also minimise the extent to which the clinical teams required to be involved with multiple bidders during the procurement as key aspects of the building lay-out, room adjacencies etc. were resolved in the reference design prior to the procurement phase. It had also been made clear through national accounting guidance issued by HM Treasury in September 2009 that the classification of the Project to the private sector, which was required to deliver additionality of investment, did not require the design risk

to be fully transferred to the private sector contractor. SFT considered that all of these benefits were of value and therefore promoted and supported the adoption of the reference design approach. This was set out in a letter I drafted to Iain Graham dated 8 December 2010, (Bundle 3, vol.2, doc 31, p.111), which states at paragraph 5.1:

"*Consideration will be needed at an early stage of how much the design should be progressed in-house and how much in competition through the NPD procurement. There is an opportunity with recent accounting rules changes to undertake more design especially overall massing, adjacencies and even layouts in-house; with the preferred bidder taking on detailed design for construction. Such a move will involve more design work ahead of the procurement, but is overall likely to save time to a start on site*."

110. Further comments on the reasons for adopting a reference design were included within the following documents:

- The Infrastructure Investment Board Paper: RHSC briefing for 26 September 2011, (Bundle 3, vol.2, doc 54, p.486), which states:

  "*NHS Lothian is developing a "reference design" for an integrated RHSC/DCN in order to facilitate a speedy delivery and minimise the up-front costs for bidders. This means that most of the design development (except in relation to mechanical and electrical design) will be done before the project enters procurement, rather than bidding contractors preparing detailed designs themselves. Although it potentially limits innovation, this approach should increase the attractiveness of the project to bidders and allow for a more certain overall cost for the project at Outline Business Case stage. As part of a 'needs not wants' challenge SFT is undertaking an independent review of the design*."

- NHS Lothian Paper for Project Steering Board Meeting titled "*RHSC + DCN Little France – Reference Design*" dated 11 May 2012 (Bundle 3, vol.2, doc 66, p.893):

"*Discussion of Key Issues*

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. These remain as previously reported:

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

- The Mott MacDonald report of May 2012 states at paragraph 2.1 (Bundle 3, vol.2, doc 68, p.909) that*:*

"The benefits offered by the use of Reference Designs in NPD projects in the health sector are as follows:

- *To give greater certainty in OBC costings;*
- *Since Operational Functionality design risk sits with the Procuring Authority anyway, this can be developed by the Procuring Authority to inform the procurement process;*

- *To give greater certainty over final design – to reduce the risk of the Board ending up with a design it does not wholly favour;*
- *To avoid detailed input being required from Clinicians during the Competitive Dialogue process where the Clinicians would have to consider in detail, three solutions with three separate Bidders;*
- *Very limited engagement of a scarce clinical resource being required during the Competitive Dialogue process*
- *Capitalises use of available programme time. At RHSC + DCN, design development running parallel with Consort Negotiations i.e. no overall delay to strategic programme;*
- *Minimises abortive design cost for unsuccessful bidders; and,*
- *To streamline the NPD procurement process thus reducing the cost and programme to both the Procuring Authority and Bidders*."

111. I have been asked to describe the role of NHS Lothian with regards to the decision to adopt the reference design approach. I am of the view that NHS Lothian was in favour of the decision to adopt the reference design approach, given all of the previous design work that it had undertaken and invested in prior to the decision being made that the Project would be revenue funded. This is reflected in the NHS Board Meeting minute of 26 January 2011, (Bundle 3, vol.2 doc 38, p.351), which states under the heading "*Procurement Options*" that NHS Lothian had an objective, amongst others, to minimise both the delay to the programme and any abortive and on-going costs and that to achieve that, NHS Lothian's ideal "*being to have utilised the exiting design work completed to date, build on the market testing of packages already undertaken and construct the new building*".

112. I also note from an email exchange on 27 September 2011 to 22 October 2011 (Bundle 7, doc 10 p.299) between Victoria Bruce (Scottish Government), Andrew Bruce (SFT), Susan Goldsmith (NHS Lothian), Brian Currie (NHS Lothian), Jackie Sansbury (NHS Lothian) and Mike Baxter (Scottish Government) that the reference design also allowed the NHS to *"ensure that some of the investment in the detailed design for a standalone*

Children's hospital was not lost following the announcement that the project would be funded through NPD".

113. I believe that the Scottish Government was supportive of the decision to adopt the reference design approach. The reference design approach was discussed at the Scottish Government Infrastructure Investment Board meeting on 26 September 2011 (Bundle 3, vol.2, doc 54, p.484) and the Scottish Government knew it was happening and agreed to it in principle.

114. I am aware that Mott MacDonald were advisors to NHS Lothian, and that on the instruction of NHS Lothian, they prepared a report titled "*RHSC+DCN Approach to Reference Design*" (Bundle 3, vol.2 doc 68, p.898). However, I do not know what role was played by Mott MacDonald, if any, with regards to the decision to adopt the reference design approach.

115. I do not know what other parties, if any, were involved in the decision to adopt the reference design approach. However, the Minute of Meeting of NHS Lothian's Board for their Finance and Performance Review Committee dated 12 January 2011 (Bundle 3, vol.2, doc 34(i), p.314) reflects the fact that NHS Lothian was in discussion with its technical and legal teams in relation to the decision. I understand that NHS Lothian's legal advisors at the time were MacRoberts LLP, as mentioned in paragraph 103 above.

116. I have been asked as to my knowledge of when the decision to adopt the reference design approach was made. On 12 January 2011, a meeting of NHS Lothian's Finance & Performance Committee 2011 (Bundle 3, vol.2, doc 34(i), p.314) considered a paper drafted by the Director of Finance and the Chief Operating Officer, which invited the Committee to:

"*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 (OGC) procurement solution."

It was also noted within that meeting paper that a "*recommendation based on legal advice for procuring the Reference Design will be available for Committee members at the meeting"*.

117. This reference to a recommendation to the Finance and Performance Committee appears to align in timing but not in relation to the decision making party with the statement at paragraph 105 of the Grant Thornton Report, (Bundle 3, vol.1, doc 2, p.43), which states:

"*105. In January 2011 it was decided by the Project Director and project board to use the completed early design work through the creation of a reference design. This was to recognise early work completed including involvement of clinicians in design and the costs NHS Lothian incurred between 2008 and 2010 on the project*."

118. The above referenced documents would suggest that NHS Lothian's Finance and Performance Committee was invited to take the decision. However, SFT does not have a Minute for that meeting so I cannot confirm whether the decision was taken by that body at that time. NHS Lothian made the decision to adopt the reference design approach, which was promoted by SFT and it is my understanding that it was supported by the Scottish Government.

119. The reference design approach was thereafter developed during the course of 2011 and 2012.

120. I have been asked to describe the role of healthcare planners in the development of the reference design. Other than what was included in the Mott MacDonald Report and the Grant Thornton Report, I do not know the extent to which, if at all, healthcare planners

were involved. I note that the Grant Thornton Report (Bundle 3, vol.1, doc 2, p.50) states;

"*173. Healthcare planners were commissioned by NHS Lothian in 2011 to support with the preparation of the COS.*

The remit was to review the COS's focused on ensuring that single clinical solutions were not presented in error, and incorrectly transferring risk to NHS Lothian which should rest as Project Co risk."

121. I further note that within the Mott MacDonald Report it states;

"*It is recognised that Bidders are likely to suggest revisiting the Reference Design during the Competitive Dialogue in order to differentiate themselves from other Bidders. NHSL will resist any such suggestions on the basis that the Reference Design represents the operational and clinical solution agreed by NHSL and Stakeholders. The absence of an external Healthcare Planner on NHSL's advisory team during procurement could be perceived as a risk. Given however the previous healthcare planning input to the project and NHSL's internal resource, this is deemed by NHSL to be a minor and manageable risk".*

122. On or around 26 May 2011, SFT raised a concern with NHS Lothian in relation to the reference design team arrangements. The concern related to bidders gaining a competitive advantage if members of the reference design team joined organisations bidding on the procurement. This is specifically set out in a letter from myself to Jackie Sansbury dated 01 June 2011, (Bundle 3, vol. 2, doc 46, p.406) in which I stated:

"*With regard to current advisory appointments we do not believe it is sensible to appoint advisors with significantly overlapping remits (as appears to be the case with regard to technical advisory appointments). Our experience is that this leads to excessive levels of*

advisory costs and more internal management time to handle this situation. We are also concerned that the architects employed to carry out the reference design for the Project are not restricted from working for one of the bidders once this stage is complete. This will make it difficult to create a level playing field amongst bidders for the Project, as at least the perception will be that whichever bidder employs this architect will be at a significant advantage. We would welcome a dialogue with you as to how these issues are resolved."

123. I have been asked about my understanding of "mandatory" and "non-mandatory" elements of a reference design. My understanding of the mandatory elements in the reference design is that bidders would be non-compliant if they did not include mandatory elements in their tender submission.

124. If the mandatory elements of a reference design are too detailed, it can stifle the ability of bidders to innovate. It is, therefore, important to strike a balance. If a design feature is specified as a mandatory element and a procuring authority expects to have that included in the final design, then it hampers the ability of the bidders to come up with different solutions which could potentially deliver better value for money and might create competitive advantage. For example, one architectural solution may include curved walls which could add cost to the building, whereas another may include straight walls, with both designs delivering the same '*Operational Functionality'*. Bidders should be free to determine their design solution to the greatest extent possible whilst meeting NHS Lothian's requirements for Operational Functionality. The different solutions offered would be evaluated through the competitive process. The process is designed to deliver the best solution through competition

125. In light of this it is important to understand what items were listed as mandatory within the reference design and the implications of being mandatory.

126. The Mott MacDonald report dated May 2012 set out to NHS Lothian how the former intended to develop the reference design work which would inform the ITPD instructions

to bidders. The Mott MacDonald "RHSC + DCN Approach to Reference Design" Report (Bundle 3, vol.2, doc 68, p.913) defined mandatory elements as follows:

"4.1 Reference Design Mandatory Elements

The Operational Functionality requirements for the RHSC + DCN will be outlined in the Clinical Output Specification, Schedule of Accommodation and the Adjacency Matrix.

The ITPD will state that it is mandatory that Bidders develop proposals that comply with the Operational Functionality solution as detailed in the Reference Design.

The Operational Functionality will be defined in the following constituents of the Reference Design:

- *1:500 Interdepartmental Layouts;*
- *1:200 Layouts; and*
- *1:50 Generic and Key Room layouts…"*

127. At the NHS Lothian Project Steering Board Meeting held on 11 May 2012 (Bundle 3, vol.2, doc 67, p.896), the Board was recommended to;

"2.1 Approve the implementation of the following as described in Section 7 Conclusions of the report "RHSC + DCN – Approach to Reference Design dated March 2012":

2.2 Mandatory Elements - comprising the information that defines Operational Functionality and as indicated in Interdepartmental Layouts (1:500), Departmental Layouts (1:200) and Room Layouts (1:50) for Key and Generic Rooms. As a consequence

of the particular project and site issues, departmental corridor layouts are also mandated as a result."

128. The Information Memorandum and Pre-Qualification Questionnaire issued to bidders stated at 1.6 and 3.2.1 (Bundle 7, doc 25 pp. 543 & 548) that:

"*The Board has, in conjunction with experienced private sector organisations, undertaken a significant amount of work to develop a reference design for the Project, parts of which will be mandated within the Invitation to Participate in Dialogue (ITPD).*"

…

"The Board welcomes and encourages Candidates to bring innovation, and expertise from within the UK and/or overseas to develop their own design proposals but it should be noted that elements of the design as they relate to operational functionality will be mandatory; as will be more fully set out in the ITPD."

129. In the draft ITPD Vol 1 (Bundle 3, vol.3, doc 74, p.178) (we have a copy of Rev K but not the final version of the ITPD), paragraph 2.5 states:

"*The mandatory elements of the Reference Design (the "Mandatory Reference Design Requirements") are those elements of the Reference Design relating to Operational Functionality. The agreed Operational Functionality is generally set out in the following constituents of the Reference Design:*

- *1:500 Departmental Adjacency Layouts;*
- *1:200 Departmental Layouts;*
- *1:50 Generic and Key Room Layouts*

…"

130. The mandatory elements of the reference design were therefore to be referred to those that defined "*Operational Functionality*". The definition of "*Operational Functionality*", related to spatial elements of the design as set out in paragraph 131 below, as opposed to any environmental or engineering aspects, such as ventilation.

131. The term "*Operational Functionality*" is a defined term within Schedule Part 1 of the Project Agreement and is as follows (Bundle 7, doc 26 p.589) :

"Operational Functionality"	means (a) the following matters as shown on the 1:500 scale development control plan and site plans; (i) the point of access to and within the Site and the Facilities; (ii) the relationship between one or more buildings that comprise the Facilities; and (iii) the adjacencies between different hospital departments within the Facilities, as indicated on the following drawings in Section 4 *(Project Co's Proposals)* of Schedule Part 6 *(Construction Matters)* • HLM-Z0-00-PL-700-020 Rev 6; • HLM-SZ-B1-PL-400-400 Rev 2; • HLM-SZ-00-PL-400-400 Rev 3;

	• HLM-SZ-01-PL-400-400 Rev 2; • HLM-SZ-02-PL-400-400 Rev 2; • HLM-SZ-03-PL-400-400 Rev 2; • HLM-SZ-04-PL-400-400 Rev 2; (b) the following matters as shown on the 1:200 scale plans: (i) the points of access to and within the Site and the Facilities; (ii) the relationship between one or more buildings that comprise the Facilities; (iii) the adjacencies between different hospital departments within the Facilities; and (iv) the adjacencies between rooms within the hospital departments within the Facilities, as indicated on the following drawings in Section 4 *(Project Co's Proposals)* of Schedule Part 6 *(Construction Matters)* • HLM-SZ-00-PL-220-001 Rev 6; • HLM-SZ-01-PL-220-001 Rev 6; • HLM–SZ–02–PL–220–001 Rev 6; • HLM-SZ-03-PL-220-001 Rev 6;

	• HLM-SZ-04-PL-220-001 Rev 6; • HLM-SZ-06-PL-240-001 Rev 5; • HLM-SZ-B1-PL-220-001 Rev 7; • HLM-Z5-SL-PL-220-001 Rev 6; (c) the quantity, description and areas (in square metres) and minimum critical dimensions of those rooms and spaces as indicated on the following drawings in Section 4 *(Project Co's Proposals)* of Schedule Part 6 *(Construction Matters)* • HLM-SZ-00-PL-220-001 Rev 6; • HLM-SZ-01-PL-220-001 Rev 6; • HLM-SZ-02-PL-220-001 Rev 6; • HLM-SZ-03-PL-220-001 Rev 6; • HLM-SZ-04-PL-220-001 Rev 6; • HLM-SZ-06-PL-240-001 Rev 5; • HLM-SZ-B1-PL-220-001 Rev 7; • HLM-Z5-SL-PL-220-001 Rev 6; (d) the location and relationship of equipment, furniture, fittings and user terminals as shown on the 1:50 loaded room plans in respect of: (i) all bed and trolley positions;

	(ii) internal room elevations; (iii) actual ceiling layouts; (iv) the Non-Clinical Services supplies, storage, distribution and waste management spaces; and (v) the ICT requirements; (e) the location of and the inter-relationships between rooms within the departments within the Facilities, as indicated on the following drawings in Section 4 *(ProjectCo's Proposals)* of Schedule Part 6 *(Construction Matters)* • HLM-SZ-00-PL-220-001 Rev 6; • HLM-SZ-01-PL-220-001 Rev 6; • HLM-SZ-02-PL-220-001 Rev 6; • HLM–SZ–03–PL–220–001 REV 6; • HLM-SZ-04-PL-220-001 Rev 6; • HLM-SZ-06-PL-240-001 Rev 5; • HLM-SZ-B1-PL-220-001 Rev 7; • HLM-Z5-SL-PL-220-001 Rev 6; but only insofar as each of the matters listed in (a) to (e) above relate to or affect Operational Use;

132. The Mott McDonald Report states (Bundle 3, vol.2, doc 68 pp.907-908) :

"1.*2 Definition of Functionality*

To date, reference has been made to Reference Design in relation to Clinical Functionality. The following note extracted from the Design Development Protocol indicates how this could lead to some confusion:

Clinical functionality refers to, and only to, the project's capacity for use by the Board or its staff for carrying out the trust's clinical functions and non-clinical functions. The Board's non-clinical functions are deemed to include all hard and soft Facilities Management services retained by the Board that are out-with the bidder's responsibility.

Since 'Clinical Functionality' refers to both clinical functions and nonclinical functions, we should refer to Operational Functionality as opposed to Clinical Functionality since some of the mandatory areas of the Reference Design will cover non-clinical functions. This is in line with the SFT Standard Form Project Agreement (NPD Model) where the reference is to Operational Functionality (See Appendix A) – largely because the standard form will also be adopted in non- healthcare projects. (Note that Operational Functionality is not defined in the Standard Form as noted in the extract in the SGHD Standard Form also indicated at Appendix A. This will need to be considered by the Procurement Workstream when developing the draft PA for inclusion in the ITPD.)."

133. For this Project, there were some additional elements of mandatory requirement in the reference design due to the particular site constraints and interfaces.

134. The NHS Lothian Paper for Project Steering Board Meeting titled "*RHSC + DCN Little France –Reference Design*" (Bundle 3, vol.2, doc 66, p.893) states:

"3.3 *The Project Steering Board are reminded that because of the particular and unique issues surrounding the development of this facility on this site, greater input and a more mature Reference Design has been necessary than may be the case in other Healthcare NPD projects.*

These issues include:

- *The connections required to the existing RIE building – predetermined by the location of the existing A&E department and Critical Care.*
- *The restricted nature of the site bounded on all sides as it is by existing road and services infrastructure and key access/egress points.*
- *Height and massing restrictions imposed by the local planning authority.*
- *Flood protection measures and Public Transport Infrastructure requirements.*
- *The site being part of an existing PFI / PPP site*
- *Interface and Access requirements with the existing RIE PFI service provider*".

135. Similarly, the Mott MacDonald Report states:

"The level of development of the Reference Design is predicated upon the definition of Operational Functionality defined in the Project Agreement. This is based on the Standard Form definition outlined in Appendix A. The constituents of the Reference Design are detailed in the matrix of Reference Design Deliverables at Appendix B. The level of development can be described as approximating the RIBA Plan of Work, Stage C – Concept Design (See Appendix C).

On the RHSC + DCN project greater input is required in the preparation of the Reference Design than would normally be the case. This is because of the particular and unique issues surrounding the development of this facility on this site. These issues include:

- *The connections required to the existing RIE building – predetermined by the location of the existing A&E department;*
- *The restricted nature of the site bounded on all sides as it is by existing road and services infrastructure;*
- *Height restrictions imposed by the local planning authority*
- *Flood protection measures required;*
- *The site being part of an existing PFI / PPP site; and*
- *Interfaces required with the existing RIE PFI service provider*

The requirement however to prepare and detail services interfaces, detailed site information, 1:50 layout drawings and attendant equipment requirements goes beyond the normal Stage C level of development thus the Reference Design should be described as being at RIBA Stage C+.

These issues have combined to make the development of the RHSC + DCN Reference Design considerably more complicated and resource intensive exercise than would normally be required in other NPD projects of this scale.

The Reference Design can be described as a graphic representation of NHSL's accepted design solution to the requirements of:

- *The Clinical Output Specification;*
- *The Board's Construction Requirements;*
- *The Soft FM Specification;*

- *The Schedule of Accommodation; and*
- *The Adjacency Matrix.*

To achieve this the 1:500 scale departmental adjacency layouts, the 1:200 scale department layouts and 1:50 scale generic and key room layouts were developed in conjunction with and signed-off by NHSL."

136. SFT raised issues in respect of the "mandatory" also known as "non-negotiable" elements of the reference design, which related to spatial considerations and building layout. SFT raised issues that could reflect on value for money considerations, consistent with SFT's role and interest in maximising the value for money of the Project. In an internal email from Donna Stevenson to Grant Robertson of SFT on 8 February 2011 (Bundle 7, doc 3 p.273), attaching the "*RHSC DCN Update extract Reference Design*" document (prepared by NHS Lothian), Donna stated;

"NHS Lothian have provided more information as to what it envisages in relation to its reference design (in a draft Committee paper upon which we were asked to comment). The relevant extracts are attached.

As you see the degree of prescription is greater than we have advised, though NHSL is saying the scope is to be finalised and Mike Baxter has issues on cost and timescale. There is a project specific issue concerning the interfaces with the existing RIE and the RIE PFI contract, which I will explain when we meet"

137. On 17 February 2012, as part of the OBC process, Donna Stevenson prepared a note (Bundle 7, doc 22 p.531) , which was shared with NHS Lothian on or around the same date, recommending that "*the Funding Conditions Template be completed to reflect the following recommendations so as to enable certain information to be completed and to set out issues which require to be delay with prior to the issue of OJEU, the ITPD documentation or on an ongoing basis as the case may be".*

138. Under the heading "Reference Design. Recommendation 4" Donna Stevenson's note stated:

"That the extent of negotiable and non-negotiable elements is developed by the Board on the basis that bidders should be provided with maximum flexibility to propose their own design and engineering solution, within defined parameters, and avoiding the need to open up the clinical adjacencies which has been settled with the Board's clinicians to date and reflecting the constraints in the site as reflected in SA6. The final position is to be reviewed by SFT as part of the Pre ITPD KSR".

139. On 26 April 2012, members of SFT met with NHS Lothian to discuss the Mott MacDonald Report "RHSC + DCN – Approach to Reference Design" dated March 2012 (Bundle 3, vol.2 doc 68, p.898), which had been instructed by NHS Lothian. In advance of that meeting, my colleague Donna Stevenson prepared a note of topics to be discussed and circulated those internally at SFT by email on 26 April 2012 (Bundle 3, vol.2, doc 65, p.889). That list included queries relative to the mandatory and non-mandatory aspects of the design. On 30 April 2012 Donna Stevenson emailed Brian Currie (Bundle 3, vol.2, doc 69, p.941) stating:

"Further to the useful meeting on reference design, as arranged, I note below the actions which we agreed.

1. You confirmed that bidders will be able to change the shape of the building eg to change curved walls or corridors to straight lines and that you will revise the paper and consider the wording to be included in the ITPD documentation to make this clear. You said that you would also look at my suggested wording in the IM/PQQ."

When Donna Stevenson references "*IM/PQQ*" above, she is referring to the "*Information Memorandum*" and the "*Pre-qualification Questionnaire*".

140. Donna Stevenson's comments in that regard were ultimately reflected in the Mott MacDonald Report, particularly at paragraph 4.1 (Bundle 3, vol.2, doc 68 p.913-914) which states;

"In *the ITPD, Bidders will be advised that features such as curved walls and the external landscaping forming part of the Reference Design are indicative only given that these have no influence on the Operational Functionality. Bidders will therefore be encouraged to apply a unique design strategy founded on sound architectural principles whilst complying with the mandatory elements of the Reference Design".*

141. On 4 December 2012, in the Pre-OJEU Key Stage Review "*Section 2: project Requirements*" number 7 (Bundle 7, doc 28 p.606) of the table states:

"SFT has raised issues as to the extent to which the Reference Design is to be mandatory and has commented on this issue in the context of the draft ITPD that clarity is required in relation to this issue.

The Funding Conditions provide that "the extent of negotiable and non- negotiable elements is developed by the Board on the basis that bidders should be provided with flexibility to propose their own design and engineering solution, within defined parameters, and avoiding the need to open up the clinical adjacencies which has been settled with the Board's clinicians to date and reflecting the constraints in the site as reflected in SA6. The final position is to be reviewed by SFT as part of the Pre ITPD SR." Accordingly the finalisation of this issue will be considered as part of the pre ITPD KSR."

142. On or around 11 February 2013 (Bundle 7, doc 4 p.275) , Donna Stevenson sent an email to Brian Currie, attaching "Volume 1 of the draft ITPD" upon which she had noted her comments. She highlighted SFT's key points in the body of the email, including comments on the reference design as follows:

"2. Reference Design: I raised again yesterday the issue which I had highlighted in my email of 25 October when I commented on the original draft, namely:

"...it would be useful to understand where the reformulation of the options available to bidders even in relation to items which are described as mandatory elements such as the layouts of the departments. The example which we gave when we met some months ago was the ability to make curved walls and corridors straight and in my email of 9 August we suggested "something along the lines of a statement that the Reference Design achieves the Operational Functionality required but the Board and that there has been full engagement with clinicians. While this represents the preferred layout, there is scope to change the layout provided the same [or an equivalent] Operational Functionality is achieved. The example of the non mandatory nature of the curved walls and corridors could be stated. Any changes would need to be evaluated by the team, including its members with clinical expertise, and the evaluation basis made clear."

143. This issue was addressed in the ITPD, as noted in SFT's KSRs.

144. SFT signed off the pre-ITPD KSR as it was comfortable with the position reached by NHS Lothian on the number of mandatory elements. My recollection is that initially NHS Lothian had wished the majority of the architectural design completed in the reference design phase to be mandatory, including elements such as curvature of particular elements of the building lay-out, which are a feature of a specific design solution rather than representing Operational Functionality. In the end, the definition of the spatial mandatory elements followed the definition of Operational Functionality, with which SFT was content.

145. SFT did not provide technical advice nor was it involved in technical decision making. The discussions SFT had with NHS Lothian as to the mandatory elements of reference design was in relation to those impacting on "*Operational Functionality*" i.e. the spatial elements as set out above.

146. In addition to the Operational Functionality definition of Mandatory Reference Design Requirements set out above, paragraph 2.5 of the draft ITPD (rev K) goes on to state (Bundle 7, doc 27 p.593):

"Other areas of Operational Functionality are contained in other deliverables within the Reference Design. Full details of the Mandatory Reference Design Requirements are set out in Appendix E (Reference Design Deliverables).

147. In the version of the ITPD (Rev K) that we have, the list of Deliverables in Appendix E that were stated to be mandatory included the environmental matrix even though it was not included within the definition of Operational Functionality.

148. The draft ITPD (Rev K) makes it clear that bidders were required to develop proposals which complied with the Mandatory Reference Design Requirements. It was the bidders' responsibility to satisfy themselves that the Mandatory Reference Design Requirements complied with the Board's Construction Requirements which included relevant technical standards:

"*Bidders are required to develop design proposals which comply with the Mandatory Reference Design Requirements.*

For the avoidance of doubt, the Board will not enter into any Dialogue on alternative solutions to the Mandatory Reference Design Requirements. Bidders proposals must be developed to reflect these Mandatory Reference Design Requirements and Bidders will be fully responsible for all elements of the design and construction of the Facilities including being responsible for verifying and satisfying themselves that the Mandatory Reference Design Requirements can be designed, built, and operated to meet the Board's Construction Requirements."

149. The Pre-ITPD KSR "*Validation of Revenue Funded Projects: NPD Programme Pre-ITPD Key Stage Review*" (Bundle 3, vol.2, doc 58, p.650) (Pre-ITPD KSR) re-iterates SFT's understanding of the approach to mandatory elements of the reference design being spatial elements relating to Operational Functionality:

"The ITPD, Volume 1 section 2.5 and Appendix E sets out the elements of the Reference Design which is being provided to bidders are mandatory. These relate to the Operational Functionality as defined in the Project Agreement and there are elements of flexibility in relation to non mandatory elements of the Reference Design."

150. The non-mandatory elements of the reference design were all of the design elements that were not specified as mandatory. The bidders could choose, subject to remaining compliant with the Board's construction requirements, whether or not they wished to include these elements within their Tender submission. The draft ITPD stated that the Board's Construction Requirements would always take precedence over the reference design for matters which do not define Operational Functionality.

151. The Mott MacDonald report states at paragraph 4.2 under the heading "*Non-mandatory elements of the Reference Design"*

"Outwith those mandated elements of the Reference Design, Bidders will have freedom to develop proposals constrained only by the requirements of the Board's Construction Requirements. Bidders will be positively encouraged to develop innovative solutions in those areas not prescribed by the Reference Design. Notwithstanding this, the information forming the Reference Design also includes elements that Bidders must address during the bidding process as follows.

As noted above, only certain elements of the information included in the Reference Design will be mandatory; those that define the Operational Functionality."

152. The draft ITPD refers to the non-mandatory elements as *"Indicative Elements of the Reference Design"* and section 2.6 of the ITPD states (Bundle 7, doc 27 p.595)*:*

"During the preparation of the Mandatory Reference Design Requirements, other information has been generated both as a by-product of preparing the Reference Design itself and as a general Project requirement as follows:

(i) FM goods handling and distribution;

(ii)Structural engineering solutions;

(iii) Building services engineering solutions;

(iv) Servicing strategies and space allocations; and

(v)Hard FM solutions and space allocations.

*This constitutes the "**Indicative Elements of the Reference Design**"*

Such information is issued to the Bidders for "information only" so that they may understand the intent of the Reference Design. Bidders must however refer to the Board's Construction Requirements for the detailed requirements for all such Indicative Elements of the Reference Design for which they will ultimately carry the risk. Bidders are advised that the Board's Construction Requirements will always take precedence over the Reference Design for matters which do not define Operational Functionality. The full distinction between Mandatory Reference Design Requirements and Indicative Elements of the Reference Design are set out in Appendix E (Reference Design Deliverables)."

153. At the NHS Lothian Project Steering Board Meeting held on 11 May 2012, (Bundle 3, vol.2 doc 66, p.893) the Board was recommended to note:

"2.3 Non Mandatory Elements - Information that has been developed to verify the feasibility of the Reference Design in terms of architecture and engineering and information developed for issue to Bidders in regard to site and servicing information".

154. I have been asked if the adoption of the reference design approach was unusual given the number of mandatory elements. SFT promoted the use of the reference design as part of the NPD programme and therefore did not deem the use of the reference design as unusual for the programme, although the difference from previous PPP projects is noted in paragraph 107.

155. I would say that the Operational Functionality and project specific spatial aspects of the reference design were reasonable to have as mandatory. Whilst I have not gone back to compare directly with other projects I have worked on, I would say that the number of mandatory elements would align with what was mandatory on other projects in the NPD programme, in my experience. However, it was unusual to have the environmental matrix included as a mandatory element (discussed paragraph 147 above), given that it was not within the definition of "Operational Functionality".

156. I believe that it is important to consider the extent to which anyone knew or understood at the time that the environmental / ventilation aspects had become mandatory. I think the process of having aspects in relation to Operational Functionality as mandatory was well understood. With regards to the environmental matrix, I think that is a different thing. I do not know what processes were in place to check that particular element. Although, ultimately, NHS Lothian and their advisors take responsibility for what was included within their ITPD.

<u>Design Assurance</u>

157. I have been asked to describe the role of SFT in respect of design assurance in the period up to the commencement of the procurement exercise. It is important to understand that design review is different to design assurance. The role that SFT played was not an

assurance role; it was not any form of assurance demonstrating that technically the design would work. The review was a value for money assessment of whether the amount of space looked right for the level of clinical activity required and whether the cost per square metre look reasonable. The end product of SFT's design review, prepared by Atkins on behalf of SFT, was not an assurance document.

158. As is stated under the "*Summary and Recommendations*" heading of the report prepared by Atkins dated 12 December 2011 (Bundle 3, vol.2, doc 57, p.571):

"*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.*

The recommendations are intended to indicate actions which will help to de-risk the specification and the reference design as the project progresses towards OBC and the preparation of tender documentation and to improve value for money."

159. SFT drafted the standard form NPD contract and undertook a detailed process regarding derogations to the standard form, whereby SFT signed-off on the contractual amendments to ensure that the standard form contract was retained unless there were project specific reasons to derogate from that. SFT therefore had a ‘hands on’ approach with the contractual position relating to the standard form NPD contract. However, SFT did not, in any way, provide technical support in relation to the design and did not review, or input into, the technical parts of the ITPD and contract documents. It is my understanding that NHS Lothian had its own external advisers to advise on this. As stated in Donna Stevenson's email to Brian Currie of 30 April 2012: (Bundle 3, vol.2, doc 69, p.941)

"I attach the table of recommendations from the Project Review. As you will appreciate, SFT is not signing off on the design. Rather at the Pre ITPD KSR, we will look to the Board to confirm that it has taken account of and implemented the recommendations. Given that the reference design is now completed it would be useful at this stage if you could return the table confirming the implementation of the recommendations. "

160. SFT's design review formed part of the pre-ITPD KSR. I made Jackie Sansbury aware of this in a letter dated 01 June 2011 (Bundle 3, vol.2, doc 46, p.400), which stated:

"As *part of an updated Key Stage Review process, that will be applied uniformly on NPD projects in the health sector, we propose to engage in the ongoing design process of the Project to provide an independent review and challenge to the overall size of the facility and its specification on behalf of the ultimate funder of the project. To do this we are likely to employ an external adviser. This should provide independent validation of some of the key high level metrics of the proposed design and a valuable external benchmark on value for money*."

NHS Design Assessment Process (**NDAP**)

161. I have been asked if, to my knowledge, a NHS Design Assessment (NDAP) took place in respect of the Project. SFT's role was not associated with the NDAP process and comprised the design review process discussed in paragraphs 157 to 160 above as part of its role in assessing value for money in the NPD programme.

162. In respect of the Project, the design review which was prepared by Atkins on behalf of SFT was for the purpose of assessing and measuring value for money. SFT did not, as part of this design review, provide any input or views as to the technical accuracy of the design or the ability for it to be deliverable.

163. My colleague Donna Stevenson of SFT met with Health Facilities Scotland (**HFS**) and Architectural and Design Scotland (**A&DS**) in August 2011. The outcome from that meeting was that A&DS and HFS were to review the design review report prepared by Atkins and consider whether there were any gaps from that design review which still need be covered. On 28 December 2011, Donna Stevenson emailed Mike Baxter (Bundle 3, vol.2, doc 59, p.655) to advise that she did not know whether or not matters had developed with A&DS or HFS. She stated:

" *In August Colin, Viv and I met with Bettina and Heather of A&DS and Peter Henderson of HFS to discuss the relationship between the SFT design review and the input of A&DS and HFS to the project review. At the meeting we agreed that we would send A&DS and HFS the independent design review report once it was completed and they will consider the gaps which still need to be covered. At the time we sent on the remit of the review to Heather.*

In view of the time which has elapsed since then (as the costing information became available) I do not know whether matters have developed. Perhaps when you are back after the festive season you could let me know whether you wish me to send on the report or whether you wish to do so in the context of any other discussions which may have taken place."

Mike Baxter replied stating:

"*Thanks. I would suggest the report is sent on and that we convene a discussion early in the new year to ensure all review activity fits together. I was discussing this with Bettina last week and we will pick up in the new year.*

Mariane - Can you organise a meeting involving me, Bettina, Norman, Donna Stevenson, Pete Henderson (HFS) and Heather Chapple (A&DS) to discuss project reviews please."

164. I can see from a meeting diary invite with the subject "*Updated: RHSC/DCN Project SFT Design Review A&DS*", issued to Donna Stevenson, Peter Henderson (HFS), Norman Kinnear, Bettina Sizeland (A&DS), Heather Chapple (A&DS) and Andrew Bruce, that the meeting mentioned by Mike Baxter above was scheduled for 20 January 2012. Whilst I cannot locate any Minutes or notes of that meeting, it appears from the email correspondence that followed the week after, that the meeting did take place. On 27 January 2012, Peter Henderson of HFS sent an email to Donna Stevenson, (Bundle 3, vol.2, doc 62, p.880) referring to the meeting of the week before, attaching a document which contained HFS's comments on the Atkins Report. The majority of the comments suggest that HFS supported the conclusions of the Atkins report.

165. On 31 January 2012, in an email sent by Heather Chapple of A&DS to Donna Stevenson and Peter Henderson (HFS), (Bundle 3, vol.2, doc 62, p.880) A&DS provide its comments on the Atkins Report. The email goes on to state:

"We understand it is expected that the recommendations in relation to the reference design and the brief will be addressed by the Board prior to the ITPD. We would be happy to:

- *help the Board capture design quality standards to be incorporated into the brief*
- *and/or help the pre-ITPD KSR consider if the 'design' recommendations (16-19 & 20 'design shape' being those most within our area) have been addressed before the reference scheme and briefing documents are presented to bidders; and Pete has suggested that HFS can carry out a high level check of the reference scheme against guidance at this point if this is not being done out by others.*
- *help with evaluating the bidders' responses to the developed design brief: for our part in relation to the design quality standards etc & HFS could carry out a high level check against guidance if this is not being done out by others.*

Once NHSL come back with their response to the recommendations please let us know how/ when we can help move forward briefing for improvements and evaluating the design responses."

166. I have been asked to comment upon a document shown to me by the Inquiry. This is a meeting minute from a meeting of the "*RHSC & DCN Reference Design Team*" of 10 January 2012. (Bundle 3, vol.2, doc 60, p.667) SFT was not in attendance at that meeting. The minute notes at paragraph 7.05:

"*NDAP Review - MML confirmed that a meeting is scheduled to take place on 20th Jan between SFT/HfS/A&DS/Scottish Government. The outcome of this meeting will determine if the NDAP review is required for NPD contracts*".

167. As is noted above, it seems a meeting did take place between SFT, HFS, A&DS and the Scottish Government on 20 January 2012. However, I have not seen any documentation or subsequent correspondence to suggest that those at the meeting discussed the requirement of a NDAP review. I do not know whether an NDAP or any other design review was carried out by HFS and A&DS. If HFS and A&DS, or any other party, reached a decision that they did not require to do an NDAP or any other design review, this was a decision which was made independently of SFT and in relation to which SFT did not provide any input.

168. I have been asked to describe the role of NHS Lothian in respect of design assurance. NHS Lothian undertook the reference design with its advisors and the reference design formed part of the ITPD. It was their project and their reference design and I assume that NHS Lothian had internal assurance processes around the material that was to be included within the ITPD. I do not know what those NHS Lothian internal processes were.

169. I believe that the facts stated in this witness statement are true. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.