Written Statement

Jacqueline Sansbury

Introduction

1. My name is Jacqueline Sansbury. I retired from NHS Lothian in 2019. I was involved in the project to plan, design, and construct the Royal Hospital for Children and Young People ("RHCYP") and the Department of Clinical Neuroscience ("DCN") ("the Project"). Initially, I was Project Sponsor as I was Director of Strategic Planning. I later moved into the team as Head of Commissioning. I have been asked to provide a written statement to the Scottish Hospitals Inquiry ("SHI") in relation to my involvement in the Project, and in particular decisions to design the RHCYP and DCN to include multi-bed rooms. I have been provided with a list of questions from the SHI and a bundle of documents. This statement seeks to answer the list of questions to the best of my recollection. Some of the events I've been asked about occurred fifteen or so years ago and, given the passage of time, I cannot recall all of the events and documents.

Background

2. I was employed by NHS Lothian as a registered nurse from 1979 – 1994; a Business Manager from 1994 – 1999; Service Development Manager from 1999 – 2001; Assistant Director of Planning from 2001 – 2003; and Director of Regional Planning for South East of Scotland and Tayside ("SEAT") Planning Group 2005 – 2008; Director of Strategic Planning from 2004 – 2010; Chief Operating Officer for the United Hospitals Division from July 2010 – July 2012; and Head of Commissioning

for the Project from 2013 onwards and stayed in that role until my retirement. I was also an Executive Director (2004 – 2008) and a member of NHS Lothian Health Board (2004 – 2012) and contributed to the corporate management and governance of NHS Lothian in those roles. As Head of Commissioning my role was to get the hospital equipped and ready, to support the staff in the old hospital getting them ready to move, to carry out the move and then to evaluate the move at the end. However, with the delays, I had retired before the services were due to move in.

The Project

3. I was involved in the Project from the outset in around 2006 in my role as Director of Strategic Planning. As the Director of Strategic Planning my portfolio included the Strategic Business Case for the new children's hospital. The need for a new children's hospital is outlined in the Initial Agreement (Bundle 3; Volume 1; Document number 3; Page 95) and also in the Outline Business Case ("OBC") (Bundle 3; Volume 1; Document number 12; Page 272). It includes factors such as the inadequacy and unsuitability of the hospital for the future, the need to provide facilities for older children given the policy to increase the age of children being cared for in children's hospitals, increasing activity levels and the need for additional modern diagnostics such as scanners.

4. In Scotland, health boards are required to follow the Scottish Capital Investment Manual (SCIM) (Bundle 3; Volume 2; Document number 33; Page 120) which includes a number of steps to follow in order to gain approval of a new project. The first step was the preparation of the Initial Agreement in 2006 (Bundle 3; Volume 1; Document number 3; Page 95), which had to be approved by the Scottish Government. The Initial Agreement is a high-level document outlining the case for change and seeking permission from the Scottish Government to move to the Business Case process. I was involved in writing the Initial Agreement. I cannot recall if I wrote it all myself or alongside someone else. The Initial Agreement would go firstly to the Executive Management Team and then to the Finance and Performance Review Committee of NHS Lothian. It would then go to the NHS Lothian Board for approval prior to

submission to the Scottish Government. Once the Scottish Government have reviewed and approved the Initial Agreement the outline business case process can commence.

5. After the Scottish Government approval of the Initial Agreement in 2006, the next step was to prepare the OBC (Bundle 3; Volume 1; Document number 12; Page 272) for their approval. The schedule of accommodation for the new hospital was one of many documents also prepared at this time following workshops with the clinical and non-clinical teams including parents. The clinical teams included people such as doctors and nurses whereas non-clinical teams are staff who have an important role in the hospital but are not clinically qualified e.g. domestic staff and porters. These groups agreed on the proposed model of care in the new hospital based on the needs of the patients and the strategic direction of services as outlined in National and Lothian strategies. At the time these strategy documents were what drove the direction of services. For example, shifting the balance of care as much as possible and increasing the age range. They are all outlined in the business case. The model of care is outlined in the OBC under appendix 6.2 'Report of proposed Redesign of Patient Pathways' (Bundle 3; Volume 1; Document number 12; Page 410)

6. I was the Project Sponsor for the Project and under SCIM guidance (Bundle 3; Volume 2; Document number 33; Page 120) this role is defined as the Senior Responsible Officer role. The two terms are used interchangeably. The Senior Responsible Officer is a senior person within the organisation with the status and authority to provide the necessary leadership and clear accountability for the project's success. They will have ultimate responsibility at Board / Executive level for delivery of the project's benefits and the appropriate allocation of resources to ensure its success.

7. As Project Sponsor I did not sit in the groups detailed at paragraph 5 above but took the output from them into the project and through NHS Lothian Committees e.g. Executive Management Team, Service Redesign, Finance and Performance Review. These are all committees that would review a business case in advance of it being presented to the NHS Board. The Finance and Performance Review Committee reviews the financial aspects and considers affordability. The Executive Management Team reviews the context, why is it needed and ensures the correct research has been done to ensure a robust business case.

8. The calculations for the bed numbers were based on modelling work from two external companies, Tribal and Capita. Doing so allowed us to bench mark our services against other children's hospitals across the country. Children's services are difficult to benchmark locally because there are very few children's hospitals in Scotland and none have the same specialities. These calculations were then subject to challenge by the clinical and management teams in Lothian and the regional planning group SEAT (South East and Tayside Planning Group). SEAT had a direct interest in the development of this new hospital as patients from their geographical board areas utilised the services of the Children's hospital. Regional Planning was the mechanism for health boards to collaborate where services were delivered across a number of health board areas. I was the Director of Planning for SEAT from 2005-2008, where my role was to support planning for the services that delivered for more than one health board. This included regional services such as cancer services and children's services. The other members who sat on SEAT were the Chief Executives and Directors of Planning from each health board. I also think there was a Medical Director, a Nurse Director and a Finance Director each from one of the participating health boards. SEAT remained involved throughout the Project because, as users, they sent patients to the service and would have to review and approve our business case to allow it to proceed.

The 2008 Outline Business Case for RHCYP

9. One of the issues considered from the outset was the most appropriate room configuration for the RHCYP, i.e. 100% single rooms or a mixture of single rooms and multi-bedded bays. The issue of moving to 100% single rooms in new hospital builds was being considered by the Scottish Government and also in other parts of the UK at the time so I was aware of it.

10. There were various clinical reasons why NHS Lothian considered that certain groups of patients should not be cared for in single bedrooms in the new hospital. NHS Lothian's findings were that the best room configuration to meet the patient needs was for RHCYP to have at least 50% single bedrooms. The decisions about the proportion of single rooms in the RHCYP were taken as a result of the consultation with the clinicians, families and nursing groups (see Appendix 6.3 of the OBC) (Bundle 3;

Volume 1; Document number 12; Page 426). The consultation with the public, clinical and nursing groups considered the clinical risks for patients arising from the proportion of single bedrooms and multi-bed bays in the RHCYP. This issue was also discussed with Morgan Jamieson and Mhari Macleod, who were members of the project team in Glasgow, as they were also building a new hospital and were considering the same issue so we liaised on this and a number of issues. There was a collaborative approach in considering whether or not to have 100% single rooms.

11. I am aware there was Interim Guidance for NHS Scotland on the Provision of Single Room Accommodation dated 15 December 2006 (Bundle 3; Volume 1; Document number 5; Page 152), and have reviewed it for this statement. I note that it was the Guidance in place at the time NHS Lothian submitted the OBC (Bundle 3; Volume 1; Document number 12; Page 272) for approval in July 2008. The Interim Guidance (Bundle 3; Volume 1; Document number 5; Page 152) allowed for beds to be provided in an arrangement of 50%, 75% or 100% single occupancy rooms.

12. On 13 February 2008 there was a Finance and Performance Review Committee meeting, at which I advised the Committee about the proposed changes re single rooms accommodation. It is minuted as follows on page 245 of the Finance and Performance Review Committee Minutes (Bundle 3; Volume 1; Document number 7; Page 244):

> 70.4.5 Mrs Sansbury advised proposed changes in regulations requiring the provision of single room accommodation was a challenge and significantly affected the accommodation foot print and cost. It was important to note that there were clinical challenge in some areas about not providing single room accommodation and some latitude might be allowed through a case made to the Scottish Government in respect of the Royal Hospital for Sick Children, although not to adult wards within the rest of the acute sector.

13. This minute indicates my thinking at the time that we would need to make a case to the Scottish Government to derogate from the proposed changes to single room accommodation.

14. On 28 April 2008 there was a SEAT meeting of the Joint Directors of Planning and Directors of Finance to discuss the RHSC OBC. I tabled the OBC and highlighted the

main areas for SEAT to note. In relation to single rooms, it is minuted that: (Bundle 3; Volume 1; Document number 8; Page 246)

i. "Despite pressure from the SGHD to plan for 100% single room provision, the OBC has been drafted to include approximately 56 [*sic*] single rooms following patient, parent and public consultation. The design will include the ability to flex space in order to maximize most efficient use."

15. I can't recall if any attendee at the SEAT meeting raised concerns about the move away from 100% single bed rooms. However, as members of their staff had been involved in the process throughout and they and their teams had approved the redesign report which was clear about the need for it would have been unlikely.

16. In light of the ongoing consideration of the single room issue at the time, I confirm that I had both written and verbal discussions with Harry Burns, the then Chief Medical Office (CMO), explaining the NHS Lothian position and the rationale as set out in Appendix 6.3 of the OBC (Bundle 3; Volume 1; Document number 12; Page 426) for seeking a derogation from 100% single rooms. I understand that NHS Lothian has conducted various searches but been unable to locate an email or letter from me to Harry Burns the Chief Medical Officer for Scotland (CMO), or a response from him approving the proposal for at least 50% single room accommodation, but I can confirm that I obtained CMO approval. I do not recall the exact date that I wrote to Harry Burns or when he responded, but I think it would have been before we submitted the OBC (Bundle 3; Volume 1; Document number 12; Page 272) because, had I not received the approval on behalf of NHS Lothian, the OBC (Bundle 3; Volume 1; Document number 12; Page 272) would have been rejected. It was my responsibility as Project Sponsor to obtain approval from the CMO. The approval was in writing although I cannot remember if this was in the form of email or formal letter.

17. The OBC was submitted by NHS Lothian in July 2008 and approved by the Scottish Government in August 2008. Paragraphs 6.5.1 – 6.5.3 of the OBC (Bundle 3; Volume 1; Document number 12; Page 311-312) discuss the question of single rooms as follows, however, they do not evidence the approval by the CMO:

6.5 Room Configurations

6.5.1 The question of single rooms or multiple bed bays has been specifically explored as part of the consultation for the initial plans for the new C&YP's Hospitals in Edinburgh and Glasgow. The main findings of both projects are that children, young people and their families want a mixture of single and four bedded bays. These findings were forwarded to the author of an early draft report on single room provision in Scotland produced by the Scottish Government Nurse Directors Group.

6.5.2 A report summarising the outcome of the Edinburgh project consultation is attached as appendix 6.3. The key points identified are:

- Children, young people and their families have stated a desire for a mixture of single and four bedded bays
- Children as part of their development require social interaction and for those unable to mobilise and confined to bed, particularly for long periods, benefit from being cared for with other children
- Nurse: patient ratio's would require to be higher with 100% single rooms due to the dependence of babies and young children for all of their care

6.5.3 This additional information has been taken account of in the recently circulated draft 5 of the report identified in point 6.5.1. The consensus of this more recent report is that 100% single rooms should be the starting point with a risk assessment undertaken to identify why this should not be the case in some specialities. Based on an initial assessment, feedback from clinical staff and from children, young people and their families, a working assumption of at least 50% single rooms is planned for the new C&YP's hospital.

18. For the reasons given at 6.5.1 – 6.5.3 (Bundle 3; Volume 1; Document number 12; Page 311-312) and Appendix 6.3 of the July 2008 OBC (Bundle 3; Volume 1; Document number 12; Page 426), it was planned (and approved) for the RHCYP to have at least 50% single rooms.

19. In November 2008, the Scottish Government's Chief Nursing Officer issued a letter containing updated Guidance on the provision of single room accommodation in November 2008 ("CEL 48") (Bundle 4; Document number 1; Page 5), which I have reviewed for this statement. CEL 48 stated that for all new-build hospitals there should be a presumption that all patients will be accommodated in single rooms, unless there are clinical reasons for multi-bedded rooms to be available.

20. CEL 48 (Bundle 4; Document number 1; Page 5) also stated that NHS Boards should implement the new guidance in all schemes that have not yet submitted Outline Business Cases. The OBC at paragraphs 6.5.1 – 6.5.3 (Bundle 3; Volume 1; Document

number 12; Page 311-312) and Appendix 6.3 (Bundle 3; Volume 1; Document number 12; Page 426) set out the clinical reasons for the multi-bedded rooms and the OBC had already been submitted (and approved) by the time CEL 48 (Bundle 4; Document number 1; Page 5) was issued. As already noted, I can confirm that I both spoke to and wrote to the CMO, Harry Burns, and obtained his approval for the room configuration of at least 50% single bedrooms.

21. On 26 November 2008 there was a meeting of the NHS Lothian Board. There was a discussion about single room accommodation raised in the context of the Royal Victoria Hospital, and I go on to reference "Representations" which had been made in respect of the RHSC. It is noted in the Board Minutes (Bundle 3; Volume 1; Document number 16; Page 580) as follows:

> 89.7 Mrs Douglas commented that at a recent visit to the Royal Victoria Hospital, discussions had suggested not everyone wanted single room accommodation as required by the Scottish Government. The Chair advised he recalled the discussion and a major issue had been about supervision levels.
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> 89.8 Mrs Sansbury commented that a lot of work had been done by the Scottish Government looking at the benefits of single room accommodation with work having been commissioned within specialties to gauge the therapeutic benefits. She reminded the Board that national guidance had now been issued and would need to be complied with, albeit exceptions could be made if a strong enough case could be presented. Representations had been made in respect of the Royal Hospital for Sick Children. The challenge for the Royal Victoria Hospital team would be to manage work space and architectural design as well as using technology links like fall monitors to ensure the single room model worked effectively. Mrs Sansbury advised that evidence suggested most people preferred single rooms.

22. I believe that when I say "Representations" had been made in respect of the RHSC, that refers to my approach to and the approval from the CMO regarding the derogation to the national guidance.

23. I have been asked about The Single Room Steering Group formed in 2006. As far as I'm aware, this was a Scottish Government group so I do not have the knowledge to say why the Single Room Steering Group was formed, what role (if any) it had in the CEL 48 (Bundle 4; Document number 1; Page 5) and what the key reasons were for the introduction of CEL 48. I do not know whether the introduction of CEL 48 lead to a review and update of all relevant technical guidance by the Scottish Government.

24. I have also been referred to the Delphi Consultation Exercise. I do not have any recollection of the Delphi Consultation. Again, as far as I'm aware, this was a Scottish Government initiative so I do not have the knowledge to comment on it.

25. I have also been referred to a letter issued by the Scottish Government's Health Finance Directorate in July 2010 (CEL 27) (Bundle 4; Document number 10; Page 144) confirming the policy that the presumption is that there should be 100% single rooms in future hospital developments (CEL 27), unless there were clinical reasons for different arrangements, which should be clearly identified in the appropriate Business Case and agreed as part of the Business Case approval process. NHS Lothian remained of the view that 100% single rooms was inappropriate for children's services and we had already obtained a derogation and the OBC was approved, so there was no need to revert to 100% single rooms.

The 2012 Outline Business Case for RHCYP + DCN

26. In November 2010 the Scottish Government announced a change to the funding of the Project from capital funding to an NPD model. NHS Lothian had no knowledge of this change in funding until the day it was announced as part of the budget.

27. NHS Lothian had already agreed that the Department of Clinical Neurosciences (DCN) should move to the Little France site. Prior to the announcement re the change in funding, the Initial Agreement for the DCN had been approved by Scottish Government in 2008 and NHS Lothian were invited by Scottish Government to develop the OBC. NHS Lothian had an OBC for the DCN re-provision ready for submission towards the end of 2009 but was asked not to submit the business case to Scottish Government on the basis that no capital was available.

28. In 2012, an addendum was proposed to the existing July 2008 OBC for RHCYP to incorporate DCN (Bundle 3; Volume 2; Document number 61; Page 672). The substance of the 2012 OBC in relation to the RHCYP remained substantively the same as in the approved July 2008 OBC (Bundle 3; Volume 1; Document number 12; Page 272). On 18 September 2012 there is a letter from Derek Feeley at the Scottish

Government to NHS Lothian's Chief Executive at the time, Mr Tim Davison, approving the OBC (Bundle 3; Volume 2; Document number 70; Page 944).

Single rooms - DCN

29. In the 2012 OBC (Bundle 3; Volume 2; Document number 61; Page 679), it is stated at paragraph 1.26: *"All new inpatient accommodation in DCN will be provided in single rooms with en suite facilities, in accordance with Scottish Government policy."* There is then a footnote which contains reference to Scottish Government; CEL 48 (2008) (Bundle 4; Document number 1; Page 5) and CEL 27 (2010) (Bundle 4; Document number 10; Page 144) on Provision of Single Room Accommodation and Bed Spacing.

30. However, further to submission of the OBC in January 2012 (Bundle 3; Volume 2; Document number 61; Page 672), due to pressure from clinicians, NHS Lothian subsequently sought a derogation to the single bed provision.

31. On 15 July 2013 at 13:32, I emailed Mike Baxter with a short paper outlining the justification for requesting a derogation to the existing single bed guidance (Bundle 4; Document Number 18; Page 187). This derogation related to DCN only, which is a purely adult hospital. I state in my email that: *"The clinicians wish to have 2 four beds wards in this are [sic] to allow for greater observations of agitated patients. This document gives details of the case mix and required observations. As you know this change was supported by David Farquharson [Medical Director] and Melanie Hornett [Nurse Director]. It would be very helpful to have Harry's position on this as soon as this is an alteration to the reference design and has to be communicated to Bidders."* [explanatory text added]

32. The short paper I am referring to in my email is titled: "Rationale for request for 2 x 4 bed wards and 16 isolation/single bedrooms and en-suites within the DCN Acute Ward" and gives details of the case mix and required observations (Bundle 4; Document number 17; Page 182).

33. I did not hear from Mike Baxter on 15 July 2013 so I emailed Harry Burns directly attaching the same paper, and state: "*I also spoke again today to Prof Siddarthan*

Chandran who leads the redesign group in DCN along with James Steers. He (and James) strongly supports this and he wanted me to stress how much clinical buy in there is to this change. He feels he has the full support of the consultant and Nursing staff." (Bundle 4; Document number 21; Page 195)

34. On 16 July 2013 at 09:12, Harry Burns responded to say *"I've already been in touch with Mike Baxter to let him know of my support for the clinical arguments."* (Bundle 4; Document number 21; Page 195)

35. On 16 July 2013 at 09:13, Mike Baxter responded to my initial email to say that he had consulted the Chief Medical Officer (Harry Burns) and that "*He has confirmed that he is satisfied with the rationale underpinning the derogation request. The request is therefor approved."* (Bundle 4; Document number 19; Page 189)

Single rooms - RHCYP

36. It is clear from the OBC itself and some surrounding documents I've been shown (discussed below) that the position in relation to single bedrooms in RHCYP was reviewed by NHS Lothian as part of the submission of the 2012 OBC (Bundle 3; Volume 2; Document number 61; Page 672).

37. In 2011 Scottish Futures Trust ("SFT"), who had a role supporting NHS Boards with procurement projects including the RHCYP and DCN re-provision, undertook a review of the project. I have been shown an Action Plan dated 29 November 2011 relating to the SFT Independent Design Review (Bundle 4; Document 15; Page 171). Point 5 of the Action Plan refers to a short paper explaining the rationale for the proportion of single rooms.

38. I have been shown the paper re the "*Rationale for the Proportion of Single Rooms in RHCYP*", which is the paper referred to in the action plan (Bundle 4; Document number 16; Page 180). The Rationale paper would have been drafted by Janice Mackenzie, the Clinical Director, with the content mainly taken from Appendix 6.3 in the OBC dated 2008 (Bundle 3; Volume 1; Document number 12; Page 426). This indicates that she,

as the clinical lead on the project at the time, carried out a review of the single bed provision in RHCYP in around 2011/2012.

39. Appendix 6 of the 2012 OBC (Bundle 3; Volume 2; Document number 61; Page 761) is the Future Service Model for Children and Young People. It sets out the principles of redesign and the findings of the consultation of NHS Lothian with patients, families and the public. It is noted that one of the outcomes of the service redesign was identifying the following key principle: *"At least 50% of beds will be in single rooms.*" There is then reference to the NHSL Single Room Accommodation Report for Children and Young People's Services – 2007 (which was Appendix 6.3 of the July 2008 OBC) (Bundle 3; Volume 1; Document number 12; Page 426) and it is stated that: "*This paper has been reviewed by the clinical teams in 2011 and the recommendations remain unchanged*."

40. The position is also narrated in the body of the 2012 OBC at paragraphs 1.27 and 1.28 (Bundle 3; Volume 2; Document number 61; Page 679):

    a. 1.27 The previous OBC for RHSC was approved in 2008 with a mixture of single and shared accommodation for children following consultation with children and families, to meet the specific needs of this age group. 58% of inpatient beds, including all adolescent, mental health and oncology beds, will be in single rooms with en-suite toilet and shower facilities, and designed for a parent to stay with their child.

    b. 1.28 The national review of single room accommodation provision included a submission from NHSL on the views of clinical staff, patients and families on accommodation for children and young people's services. The NHSL review was quoted by the Scottish Government Steering Group in their 2008 report [Scottish Government (2008); *Single Room Provision Steering Group Report*].

41. Paragraph 2.8.2 of the RHCYP + DCN FBC (Bundle 3; Volume 3; Document number 76; Page 748) states that *"the model of care that was signed off at OBC has been reviewed and confirmed as valid."* It is then noted that in relation to further planning assumptions for children and young people's services include: "59% of inpatient beds, including all adolescent, mental health and oncology beds, will be in single rooms with en-suite". There is a footnote to this provision which states it is "*Approved by the Chief*

Medical Officer (2008)." This footnote is likely to be a reference to the approval I obtained from the CMO, Harry Burns, in 2008, but I cannot say for certain.

SHTM 03-31

42. I have been asked about the ventilation guidance, SHTM 03-01, Table A1 (and its predecessor SHTM 2025) The clinicians and families would not have given consideration to the ventilation guidance when making the case to derogate from single rooms either in RHCYP or DCN. That was the role of the technical advisors. I cannot recall what was said to potential bidders about how ventilation guidance should be applied to multi-bed rooms as this was part of the technical documentation. I was not personally involved in the preparation of this documentation.

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

I, Jaqueline Sansbury, confirm that:

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

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

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

Signature: Jacqueline Sansbury

Date: 25th April 2022