Scottish Hospitals Inquiry
Witness Statement of
Peter Henderson

Witness Details

1. My name is Peter Henderson. I am aged ██.

2. I am a retired architect and was employed by NHS National Services Scotland ("NHS NSS") as Principal Architect. I was in this role from 2009 to 2013.

Qualifications

3. I graduated with a BA(Hons) in Architecture from Heriot-Watt University in 1973.

4. I later obtained an LLM in Construction Law from the Universities of Strathclyde and Glasgow in 2005.

5. I was a member of the Royal Institute of British Architects ("RIBA") and Royal Incorporation of Architects in Scotland ("RIAS") from 1974 until my retirement from Health Facilities Scotland ("HFS") in 2013.

Previous Roles and Experience

6. I was Principal Architect for HFS, which is a division of NHS NSS, between 2009 and 2013. My role in this post was to provide expert strategic professional advice to the NHS in Scotland and represent NHS NSS in dealings with other organisations in property and capital planning. Additionally, I was required to identify key initiatives by researching best practice and innovative thinking in the field of design, property, and capital planning which would impact the NHS in Scotland. I was also expected to manage and contribute to the development and dissemination of best practice

guidance through document production, forums, workshops, seminars, and national conferences.

7. I was Technical Director at Capita Symonds Construction Consultants where I worked from 1996 to 2009. At Capita, I worked on major new hospital projects throughout England and Scotland being procured under the Private Finance Initiative (“PFI”) initiative. I assembled a team of professionals to carry out due diligence for funding bodies and to certify that projects had been completed in compliance with the Project Agreement.

8. Between 1990 and 1996, I was Director and Co-owner of Blueprint Architects. In addition to building design work, I acted as energy consultant to BAM Construction and assisted them in setting up a unit to be called ‘ecostruct’ that would provide energy efficient sustainable buildings.

9. I was Director of Architecture at Kaiser Bautechnik between 1988 and 1990. In this role, I prepared development proposals and liaised with clients to explain the benefits of energy efficient sustainable design and in particular the use of passive solar applications.

10. I was at GRM Kennedy and Partners as an Architect and Partner between 1974 and 1988. I designed a range of educational, residential, industrial, and commercial buildings.

Recollection of Events

11. I took up the post of Principal Architect in the Property and Capital Planning section of HFS in January 2009 and retired from that post in June 2013.

12. This written statement is my recollection of events which took place thirteen years ago in relation to the Royal Hospital for Children and Young People (“RHCYP”) and Department of Clinical Neurosciences (“DCN”) in Edinburgh. As a result of my retirement I have had limited access to files or

correspondence and my personal A4 notebooks relating to the period under investigation. I have been unable to have dialogue with others with whom I worked closely at the time. I do not remember these events at all well. Although I have tried to be accurate, there may be things I have forgotten to mention or that I am misremembering.

Role of HFS in RHCYP/DCN Project

13. As far as I know, the Property and Capital Planning section of HFS had no formal role in this project.

14. At the time of my employment at HFS, the development of the business cases for projects was the responsibility of the Health Boards who were required to follow the detailed procedures for each approval stage of projects set out by the Scottish Government in the Scottish Capital Investment Manual ("SCIM") **(A35299820 - SCIM Supporting Guidance Design Assessment in the Business Case Process)[1].**

15. A Board's management of this process was usually carried out by a specific Project Board set up for each project under the direction of a Project Director selected from Board staff.

16. SCIM did not identify any role for HFS in relation to the development of any of the business case stages. If the Board/Health Finance Directorate had made us aware of the project at its outset HFS may have had a role in carrying out the NHS Scotland Design Assessment Process ("NDAP"). I believe this project was already underway prior to the development of NDAP.

17. The Property and Capital Planning section of HFS did not to my knowledge have any role in the development of the environmental matrix or the reference design.

[1] Bundle 10 – Miscellaneous, Volume 1(of 2), item 9, p.46

18. HFS Property and Capital Planning did not have a role in respect of design assurance for Board construction projects.

19. NDAP is an "assessment" of design quality, that is an "evaluation" of the design, not an "assurance" of compliance with standards. I would expect the professionals who are employed by the Health Board to design and construct NHS buildings to maintain robust quality assurance systems as part of their normal responsibilities for construction developments. The architect's professional obligation is to meet all the requirements of his brief. He does not normally have any external body overseeing his work other than statutory bodies such as the building control authority, planning authority and the like.

20. HFS could have had a supporting role if requested by the Board in relation to the SCIM requirements relating to the Achieving Excellence Design Evaluation Toolkit ("AEDET") **(A39822335 – AEDET Toolkit 01-2008)**[2], achieving the desired BREEAM rating, and the use of ADB ("Activity DataBase").

21. I was asked to comment on an email chain including an email from David Stillie dated 6th February 2012. **(A37318834 - Email from David Stillie at MML to Thomas Brady at Davis Langdon - 6 February 2012)**[3] I have no recollection of the telephone call or the meeting referred to in David Stillie's email.

22. I don't think I met David Stillie, there is no reference in the email to us having met, only reference to a phone call with me. This email was sent eleven years ago and concerned a project that I had very little involvement with. I note David Stillie's quote that I said all present at the meeting referred to "appreciated that RHSC/DCN project had been reviewed to death" but he does not indicate which attendee at the meeting suggested that this was the

[2] Bundle 10 – Miscellaneous, Volume 2 (of 2), item 39, p.991
[3] Bundle 10 – Miscellaneous, Volume 1 (of 2), item 15, p.117

case. I think that there had been a Design Review by an Architecture and Design Scotland panel and a review by Atkins for SFT (“Scottish Futures Trust”) that I commented on, but those would be normal reviews to be expected on a project of that size. I don’t know why I would have joined in the opinion that it had been “reviewed to death”.

23. I have no recollection of having had any meetings with SFT on the subject of whether or not the project should be included in NDAP.

Achieving Excellence Design Evaluation Toolkit (AEDET)

24. In the overview of AEDET (which is available on the SCIM website, Supporting Guidance AEDET guide at https://www.pcpd.scot.nhs.uk/Capital/scimpilot.htm) **(A40190756 - AEDET Refresh Guidance (2017)**[4] it specifically states that *“AEDET is a tool specifically directed towards achieving excellence in design rather than ensuring compliance with legislation, regulation and guidance.”* AEDET looks at how people relate to the building and how it works for them. That is why in facilitating an AEDET workshop, it is important to invite a range of participants: the Health Board, clinical staff, maintenance staff, and members of the public such as patient association groups. This gives a cross-section of stakeholders who will be involved in the scoring process. They will not all be experts in the design or construction of NHS buildings.

25. If the Q&A scoring sheets are examined (see Supporting Guidance: AEDET spreadsheet at https://www.pcpd.scot.nhs.uk/Capital/scimpilot.htm) **(A42945853 – AEDET Refresh Spreadsheet)**[5] it can be seen that in general they do not require technical expertise in order to establish a score. For example, even in the section on engineering, the seven questions asked are fairly simple questions such as “are the engineering systems well-designed, flexible, and efficient in use?” The scoring group would look to see if there was someone qualified to assess that and let him/her explain his proposed

[4] Bundle 10 – Miscellaneous, Volume 2 (of 2), item 38, p.958
[5] Bundle 10 – Miscellaneous, Volume 2 (of 2), item 37, p. 939

score then pass on to the next question. If no one can answer they move on to the next question, the system does not require all questions to be scored. AEDET does not go into any level of engineering or construction detail and was never intended to.

26. I have no knowledge of the stage of development of the design at March 2012 so I do not know if the Engineering section could have been scored, but it can be seen from the questions in the spreadsheet that a score would have had no relation to the detailed design of the ventilation (or any other) system.

27. As part of my role in HFS, I would encourage the Health Boards and their design teams to use AEDET at all stages of construction projects as required by SCIM. The AEDET toolkit was developed by Professor Bryan Lawson and Dr Michael Phiri of the University of Sheffield for the NHS in England. It was also adopted for use by the other three National NHS authorities. The purpose of AEDET was to improve the impact of the NHS built environment on patients and staff through evidence based design. The AEDET toolkit can be applied at all stages of the design process from inception to completion by only using sections appropriate to that stage. For instance, where the design development had not yet developed to detailed consideration of the building services that section does not need to be included in the review.

28. Architects can use the toolkit themselves at the earliest stages of their design but as the design develops the review is normally facilitated by someone outwith the design team with the assessment being made by a representative group of stakeholders including patient groups, clinicians, and others.

29. When requested by Health Boards I acted as a facilitator on AEDET reviews as it was preferable to have a facilitator from outwith the project team to maintain an unbiased appraisal of the project.

30. NHS Lothian did not request my assistance in this case.

NHS Scotland Design Assessment Process (NDAP)

31. “A Policy on Design Quality for NHS Scotland” was introduced in 2006 and, what was at that time, the Scottish Executive Health Department entered into a framework agreement with Architecture and Design Scotland (“A&DS”) to aid the implementation of the policy.

32. Around 2009, Michael Baxter of the Health Finance Directorate raised some concerns that the policy was not being implemented consistently across all of the Health Boards. Michael Baxter called Heather Chapple of A&DS and myself to a meeting to discuss how this could be improved. One of the areas discussed was that the design guidance documents made available by HFS (including the Scottish Health Planning Notes and Scottish Health Technical Memoranda) were not always being referred to by the Health Board’s design teams. The outcome of the meeting was that Heather and I should put forward a proposal to develop a process that would improve compliance with the Policy on Design Quality and the awareness and use of the design guidance Published by the NHS.

33. The outcome of this was the development of the NHS Scotland Design Assessment Process (“NDAP”) **(A35299820 - SCIM Supporting Guidance Design Assessment in the Business Case Process)[6].**

34. The process was mapped on to the SCIM business cases and required Health Boards to become involved with NDAP prior to the Initial Agreement stage by preparing a ‘Design Statement’ which set out in detail the Board’s aspirations for the project. After acceptance of the Design Statement by A&DS/HFS, the project would be assessed at each of the three stages of the business case process against the Design Statement, before its submission for business case approval for that stage. Assessment would also include a

[6] Bundle 10 – Miscellaneous, Volume 1(of 2), item 9, p.46

review of the use of the NHS guidance documents and the status of other requirements such as planning permission.

35. The NDAP was later included in the 2011 revision of the SCIM with a section on Supporting Guidance explaining the process.

36. To my recollection, this project did not go through the NDAP. I believe the main reason being that the NDAP process was dependent on the production of a Design Statement at the outset of the project and Scottish Government decided that it was not therefor appropriate for NDAP to be applied to a project that had already passed the Initial Agreement stage. I think that was the case for this project.

37. I do not believe that an NDAP as set out in SCIM could have been carried out for this project as the design was too advanced and as far as I am aware a Design Statement had not been prepared. To realise the benefits of NDAP, it is necessary for it to be initiated at the commencement of the decision to build. That is at or before the Initial Agreement stage of the business case approval process in SCIM. This is necessary in order that the Board can put together their Design Statement against which the project will be assessed. It also means that areas such as the preparation and development of the brief, selection of sites etc can be assessed.

38. Without further investigation and access to files, I am unable to confirm what stage these projects were at in July 2010 but I believe they were past the initial agreement stage and approaching Outline Business Case ("OBC") in an advanced stage of design development.

39. From my perspective as one of the originators of NDAP, its purpose was to improve overall design quality. It was intended to confirm that the appropriate NHS guidance was being considered by the designers but it was not intended to provide close scrutiny of every detailed element of the design for compliance with every element of the recommended technical standards for construction projects.

40. It should be noted that while use of the SHPNs and SHTMs was a requirement in SCIM all the items of guidance within the documents are not necessarily intended to be mandatory. Many areas put forward as guidance direct the designers towards achieving best practice but may allow them a level of interpretation to suit the particular circumstances of the project involved.

41. I have no knowledge if subsequent Non-Profit Distributing ("NPD") projects were subject to NDAP as I retired in 2013.

42. My recollection is that when we were developing the NDAP process, we assumed a fairly traditional design and procurement model going through the SCIM business case route as the standard for setting it up. We were aware at that stage that adaptation to NDAP might be required to apply it to the PFI or NPD procurement route but we had not progressed that by the time I retired in 2013.

43. I have no recollection of advice being requested or given by the Property and Capital Planning section of HFS to the Scottish Ministers, NHS Lothian, Scottish Futures Trust or any other party with regards to whether an NDAP assessment should take place. There was a programme of work listing projects coming forward. If the development of a project had not started and it had not reached Initial Agreement, then it would automatically be put on the list for an NDAP. (Subject to a minimum capital value of £5 million at that time, I think.)

44. The requirements are now stated in SCIM in relation to whether or not an NDAP should be carried out.

45. By the time I retired, none of the projects that I was involved in were past OBC stage. They were mostly primary care projects and other smaller projects. It was certainly never the intention, as far as I was concerned, for us to carry out detailed checks for compliance with all areas of the technical guidance. Ensuring compliance of the design is the responsibility of the

designer. For an external body to carry out a full check for compliance with all relevant guidance it would require the employment of a full shadow design team. (This level of involvement could potentially diminish the level of liability of the original designer). I did not anticipate that HFS would ever take on that responsibility, but none of the projects that I was involved in had reached the detailed design stage in any event. When the first projects were going through NDAP only two personnel were involved in processing the submissions, me from HFS and Heather Chappell from A&DS.

46. From 2011 when I reached ( ), I reduced my working hours to 30hrs/week or 4 days.

47. In my previous employment, I did carry out the role of Independent Tester on PFI projects for NHS Hospitals in England. In that role I was involved in confirming that the building had been constructed in compliance with the contract. As the employment of shadow construction teams is not practical or affordable we used a team of professionals to check that the contractor had developed robust quality assurance systems and monitored that they were being implemented. We then made targeted inspections in critical areas to verify this. However these procedures were during the construction stage and I have no knowledge of an equivalent process ever being carried out on a professional design team at the pre-construction stage.

Business Case Approval

48. The approval of the business cases was the responsibility of the Scottish Government's Capital Investment Group (CIG) who reviewed and approved the business case at each of the three stages. A senior member of staff from the Property and Capital Planning section of HFS may have attended the CIG board meetings which were chaired by Scottish Government.

49. Prior to the submission of the business case to CIG by the Health Board, HFS in conjunction with A&DS would submit a report to CIG on the current status of the NDAP.

HFS Involvement in Development and Approval of the Business Case for the Project

50. As far as I know, no individuals from the Property and Capital Planning section of HFS were involved in the development of business cases for the project.

51. If there was a representation of HFS on the CIG at that time they may well have taken part in the approvals but I have no knowledge if that was the case or who that would have been.

52. I understand there is an email chain involving Donna Stevenson, Colin Proctor, Andrew Bruce, Heather Chapple, and myself **(A33335953 - Email chain - Donna Stevenson, Colin Proctor, Andrew Bruce, Heather Chapple, Peter Henderson - 27 to 31 January 2012)**[7] in which Heather Chapple states "Pete has suggested that HFS can carry out a high-level check of the reference scheme against guidance at this point if it is not being done by others". The drawings that were sent to Heather were presumably of the reference design and she forwarded them on to me. I do not know their origin. The high-level check that I made involved examining the drawings provided in relation to their compliance with Scottish Health Planning Notes ("SHPNs") guidance, which is generally planning and construction information rather that engineering information. For example, I would be looking at the adjacencies of areas such as A&E to Theatres to wards etc.; movement into and around the building; space requirements, corridor widths and room sizes etc. I would spend a day looking at the drawings to see if there was anything that appeared not to comply with the SHPNs.

[7] Bundle 8 - Scoring & Correspondence Regarding Issues, item 9, p.38

53. I was not talking about doing a technical review in terms of Scottish Health Technical Memorandum (**“**SHTMs”). The SHTMs mainly cover Mechanical and Electrical Engineering (M&E) relating to NHS buildings and these are the responsibility of the Engineering section of HFS, however there is a smaller number of SHTMs relating to the building structure that came under my remit such as, sound insulation between rooms, construction of partitioning, doors and windows, ceilings, sanitary ware, ironmongery etc. The information provided for the “high level review” was simply a set of floor plans with no construction information so a technical review was not possible at that stage. No M&E information was provided.

Scottish Health Technical Memorandum (SHTM)

54. I was asked whether HFS were “experts” with regard to SHTM requirements or whether that would fall to the recipients or users. In my role in the Property and Capital planning section of HFS we normally received documents from the NHS in England and where necessary edited and adapted them for use in Scotland. This required a degree of understanding of the requirements of the document but not to the same level of expertise as the authors. The SHTMs that I was responsible for as an Architect differed from the Engineering SHTMs in their level of technical complexity and I cannot comment on them. The designers and contractors would require a level of expertise sufficient to understand and implement the requirements of the SHTM

Environmental Matrix for the RHCYP/DCN

55. This is a subject for the Engineering Section of HFS as this Matrix is part of an Engineering SHTM. However as a matter of procedure I would not expect the preferred bidder on a current project to contact HFS directly for advice relating to it. Normal practice would be for the bidder to put any queries they had to the Board or to the Board's consultants, who might then pass them on to HFS if they required our advice. At Property and Capital Planning, I would not expect a contractor or a consultant working on a project for a

Health Board to contact me concerning it without obtaining the Boards consent first.

56. I am aware of the requirement to develop Room Data Sheets (RDS) before financial close in PFI projects but I was not involved in the RHSCYP/ DCN project.

Activity Data Base

57. In relation to Activity DataBase ("ADB"): The English Department of Health, who were responsible for writing and publishing the NHS Guidance documents which we would then adapt for use in Scotland, were also responsible for managing ADB from which the Room Data Sheets are developed.

58. Around the time of this project the UK Government were of the opinion that NHS Design Guidance, should be the responsibility of the private sector. As a result of this policy they closed the NHS Estates department responsible for procuring and publishing the guidance documents. The sub-contractor who originated and distributed ADB on behalf of NHS England, was then in an awkward situation as they were still in contract supplying ADB to Architects throughout the UK who paid for use of the software, but they had no contact with the NHS who previously provided the content for the database. This situation, which was not resolved for several years, could have caused designers and contractors to question the reliability of using ADB and perhaps use other equivalent tools.

59. I have not been involved in a Healthcare project which did not use ADB and RDS. That is not to say it was not done. My experience with RDS is mostly in their use during the construction and hand-over stages of projects. Questions on the preparation of RDS would be better addressed to the current Principal Architect at HFS Susan Grant who has direct experience of designing hospitals and preparing RDS.

60. At Property and Capital Planning in HFS we did not review RDS between preferred bidder stage and financial close. The Health Board and/or their professional consultants would fulfil this task. In addition to technical checks it would be normal to also have a clinician checking the RDS.

61. I do not know the detail of the project, so it is difficult for me to imagine how it all worked, but HFS certainly would not be involved unless someone specifically asked us to look at them. HFS was always available to the Health Boards if they needed assistance within an area of our expertise but it would be unusual to ask us to check what is effectively construction information.

Building Research Establishment Environmental Assessment Method (“BREEAM”)

62. BREEAM was a part of my role at Property and Capital Planning. I had attended training at BRE (the Building Research Establishment) and I was qualified to carry out BREEAM assessments. I arranged for someone on each Board to go through similar training, not so that they could carry out the assessment themselves, but so that they had a good understanding of how the assessments were made and how compliance could influence the design.

63. In the Inquiry Provisional Paper 1, page 14 at the end of paragraph 3.8 **(A41315349 – Provisional Position Paper 1 – Reference Design – Published Version)**[8] there is a quote from CEL 19 stating that a BREEAM “Excellent” rating is a requirement for new buildings in this category. I think this was a misunderstanding of the BREEAM process by SGHD (Scottish Government Health Directorates). It is not possible to guarantee the attainment of an excellent rating at the Final Business Case (FBC) stage of a construction project as the BREEAM assessment continues past handover and into the period of occupation of the building before an award is confirmed by BRE. I think that is why the earlier requirement stated that Boards should “seek**”** to obtain an “excellent” rating for a project.

[8] Bundle 11 – Provisional Position Papers, item 1, p 3

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