Scottish Hospitals Inquiry

Witness Statement of

Alan Morrison

Introduction

1. My name is Alan Morrison. I am a civil servant employed by the Scottish Government as the Deputy Director of Health Infrastructure and Sustainability, a Scottish Government Health and Social Care Directorate.

2. The Inquiry already has evidence within the witness statements provided previously by myself and Mike Baxter (dated 11th and 20th April 2022, 14th February 2023, and 4th April 2023) and in Mike Baxter's oral evidence to the Inquiry on 16th May 2022 as to the Scottish Government's (and the Scottish Government's Health and Social Care Directorates' (SGHD) role and responsibilities in relation to the design and delivery of large healthcare projects, including The Royal Hospital for Children & Young People / Department of Clinical Neurosciences (RHCYP/DCN). This statement supplements the evidence that is already before the Inquiry and addresses the following:

    a. My professional background and qualifications.
    b. My role in Scottish Government between July 2019 and March 2021.
    c. National Services Scotland (NSS) Assurance Reports and KPMG findings.
    d. Reporting Lines in relation to the RHCYP/DCN.
    e. The Oversight Board.
    f. Supplementary Agreement 1.
    g. Escalation of the RHCYP/DCN project.
    h. Problematic/Challenging Areas.
    i. Commercial Challenges in Negotiations.
    j. COVID/Brexit.

k. The Royal Hospital for Sick Children (RHSC) at Sciennes and The Department of Clinical Neurosciences (DCN) at the Western General Hospital.
l. Communications with the Cabinet Secretary; and
m. Some reflections on the RHCYP/DCN project.

Professional Background and Qualifications

3. I am a civil servant employed by the Scottish Government. My background is in accountancy, and I have a professional accountancy qualification from the Chartered Institute of Public Finance and Accountancy which I obtained in 1998.

4. I have been employed by the Scottish Government since April 2003. During that time, I have worked in the Health Finance Directorate in a number of different roles as a qualified finance professional. Between January 2015 and March 2020, I was the Capital Accounting and Policy Manager for Health Infrastructure.

5. I am currently the Deputy Director of Health Infrastructure and Sustainability for the Scottish Government and have held this role since March 2020. While my job title changed between January 2015 and the present day, the duties have remained broadly the same, the main duties of which are:

- Developing and delivering the Capital Investment Strategy for the Health Portfolio, ensuring that it aligns with the infrastructure priorities of the wider Scottish Government, including delivering sustainable economic growth and delivering a lower carbon economy.
- Managing the portfolio's capital budget of £0.5 billion, ensuring that a breakeven position is delivered each year, that the expenditure supports the portfolio's strategic priorities and that value for money is delivered.
- Chairing (from December 2015) the Scottish Government Health and Social Care (SGHSC) Capital Investment Group (CIG) which oversees the review and scrutiny of all business cases submitted to the Scottish

Government Health Directorate (SGHD), as well as being the lead official for the national infrastructure board.

- Interpreting HM Treasury and Scottish Government capital accounting and budgeting guidance and subsequent provision of advice to NHS Scotland finance professionals through working groups and written guidance.
- Leading the development of strategic advice to Ministers on the options and opportunities for prioritising, financing, and delivering infrastructure investment, including how it can help enable service reform and support clinical priorities.
- Managing and developing the capital accounting and policy framework for NHS Scotland that ensures compliance with HM Treasury and Scottish Government accounting, budgeting, and legislative requirements. This includes effective management of the capital investment programme and of property transactions, as well as performance management.
- Managing assurance processes in respect of major capital programmes of work by health boards: as well as engagement with internal stakeholders, one of my key responsibilities in this regard is to develop and maintain links with a range of external stakeholders including other national groups, applying specialist knowledge and skills to review, analyse and manage risks.

Role in Scottish Government between July 2019 and March 2021

6. I have been asked by the Inquiry about my role between July 2019 (when the decision was taken to delay opening of the RHCYP/DCN) and March 2021 (when the hospital opened in full).

7. I was the Scottish Government lead for healthcare infrastructure and the first point of contact for any issues arising in relation thereto. I also managed the NHS health portfolio for the Scottish Government. This meant that I had involvement with all healthcare projects (including maintenance of the existing estate) that benefited from Scottish Government investment as well as managing the government budget that supported such projects.

8. Between July 2019 and March 2021, I worked almost exclusively on the RHCYP/DCN project.

NSS Assurance Reports and KPMG Findings

9. I have been asked by the Inquiry about my involvement in instructing the assurance reports from NHS National Services Scotland (NSS): whether this was something that they would not ordinarily do and whether there would be any resourcing issues associated around that and referred to the following document **(A41232683 - NHS Lothian – Edinburgh Childrens Hospital – Action List 9 July 2019 – Bundle 13, Volume 3 - Page 45)**.

10. By way of context, nearly all significant decisions in relation to the delayed opening of the RHCYP/DCN were taken by the Cabinet Secretary, Jeane Freeman. She very much owned the issue from the day that she was notified that there was a problem with ventilation in the critical care unit at the RHCYP. The Cabinet Secretary would determine what she wanted to happen and then it would be the responsibility of me and others in government to carry these instructions out. The NSS Assurance Reports were commissioned on the instruction of the Cabinet Secretary.

11. In respect of the Assurance Report, I spoke to Health Facilities Scotland (HFS) and told them there was to be a review of the hospital. I asked how they would go about this and what they needed to allow them to carry this out. HFS then worked up their own proposal.

12. I have been asked by the Inquiry to review an email sent by me on 5 July 2019 regarding the assurance work that had begun and the timescale for completion **(A41231996 - Email from Suzanne Hart to Shirley Rogers et al providing a transcript from Jeane Freeman to Good Morning Scotland 6 – Bundle 7, Volume 1 (of 3) - Page 84).** In particular, I have been asked about the following text:

"I am expecting a proposal later today which I will circulate when it is available. Just so that it does not come as a surprise, myself and Jo spoke to HFS/HPS yesterday about timescales and they were indicating that a comprehensive review of the new site could take as long as four months to complete. They recognise that that is probably longer than we were hoping for, so they may provide options which involve a quicker turnaround, but slightly less assurance."

13. As I explained earlier, HFS had been asked to undertake a technical assurance review of the RHCYP/DCN site. I had been in initial discussion with HFS in relation thereto and was reporting back the outcome of those discussions to Shirley Rogers (NHS Scotland Chief of People) and Professor John Connaghan (NHS Scotland Chief Performance Officer). The email was updating Shirley and John as to HFS anticipated timescale for review.

14. In due course, NSS produced its reports quicker than the four months noted in this email. That is not because they were asked to undertake any less thorough an assurance process than had been discussed with them.

15. In my opinion, the NSS reports speak for themselves as regards the comprehensive nature of the review that was undertaken. While the Scottish Government had provided NSS with the instruction to prepare the reports we were, for the most part, reliant on NSS to identify what they needed to provide assurance that the building was a safe healthcare environment.

16. In the same email, at paragraph 9 line 2, I commented:

"I think it would be disingenuous to suggest that all new builds now involve HFS, if for no other reason that HFS don't have that many engineers that they can deploy, so I think it's better to say that they will involve HFS."

17. I have been asked by the Inquiry to expand on this point and what were the limitations on HFS' resources. I was reporting back on my initial discussions with HFS re their potential future role in providing "technical assurance" for new healthcare projects. I was making it clear to John and Shirley that HFS were not, at that time, able to be actively involved in all new healthcare projects by reason of their capacity to undertake such work.

18. At that point, HFS did not undertake the type of technical assurance work that was being postulated. This is the work that NHS Scotland Assure now does. I have provided the Inquiry with a separate statement detailing the creation of NHS Scotland Assure and its role in new healthcare projects.

19. I have been asked by the Inquiry to explain the role of Health Resilience. Health Resilience are a division of Scottish Government Health and Social Care that are involved in planning how we make sure that services continue to be delivered against a number of risks. For the RHCYP/DCN that was power outages, floods, and pandemics. They were thinking about contingency plans and business continuity, and they had a role in at least thinking about what we needed to do and had good experience about dealing with unexpected events that had not been planned for.

20. I have been asked by the Inquiry if I accepted KPMG's findings that they were painting a positive picture of governance in the period up to the identification of the critical care ventilation issue **(A41226194 - 2019-20 – Health Finance and Infrastructure – Edinburgh Sick Kids – KPMG Report – 16 August 2019 - Bundle 7, Volume 3 (of 3) - Page 111) and (A41228407 - Briefing to Cab Sec – Sick Kids Hospital – 23 August 2019 - Bundle 7, Volume 3 (of 3) - Page 184).** I did not really see it as my role to accept them or not. KPMG had undertaken a detailed review of what had happened and prepared the associated report. This went to the Cabinet Secretary for her information, awareness and sign-off. As far as I can recall there was no substantial disagreement with KPMG's findings or recommendations.

21. In response to an email **(A41231824 - Email from Alan Morrison to the Cabinet Secretary providing an further urgent briefing dated 10 September 2019 - Bundle 7, Volume 3 (of 3) - Page 533)**, I have been asked by the Inquiry if I am able to breakdown further the costs associated with the work done between July 2019, when the decision was taken by the Cabinet Secretary, and the completed opening of the hospital in March 2021. The report submitted to the Oversight Board dated 25 February 2021 contains a breakdown of these costs **(A44611639 - Summary of Estimated Delay Costs dated 25 February 2021 – Bundle 13, Volume 4 - Page 426)**. The costs associated with the delay were in the region of £17 million and the table containing the relevant breakdown is copied below.

Summary of Costs Associated with Delay	
Costs associated with new hospital	**Estimated Cost £k**
High Value Change 107 - ventilation works	8,554
Medium Value Change 127 - CAHMS	451
IHSL Advisor Fees	1,269
Total: Costs associated with New Hospital	**10,274**
Costs of maintaining existing sites	
Dual running of existing sites: RHSC/DCN staff	254
Dual running of existing sites: RHSC/DCN equipment/supplies	245
Additional maintenance / property costs at current RHSC and DCN facilities (energy, rates, building maintenance)	1,661
Additional capital investments in current RHSC	539
Additional capital investments in current DCN	110
Total: Costs of maintaining existing sites	**2,808**
Project Team costs (Director of Finance)	
Project Team costs	3,127
Reviews & SA2	620
Total: Project team costs	**3,747**
Contingency	
Contingency	-
Total Spend/ Estimated Additional Costs	**16,830**

Reporting Lines

22. I have been asked by the Inquiry what reporting lines were in place for the issues within the hospital. We (Scottish Government) all reported to the

Cabinet Secretary, Jeane Freeman, who, at the outset, was virtually meeting with us on a daily basis. I also reported to the Director General, Malcolm Wright (Chief Medical Officer), Dr Catherine Calderwood (Chief Nursing Officer), Professor Fiona McQueen, and Christine McLaughlin (Finance Director.

Oversight Board

23. Following the decision to halt the planned move to the new Hospital facilities on 9 July, the Oversight Board was established to provide independent advice to ministers on the readiness of the facility to open and on the migration of services to the new facility **(A41232145 - NHS Lothian RHCYP Oversight Board Terms of Reference – July 2019 - Bundle 7, Volume 2 (of 3) - Page 352).**

24. In order to provide co-ordinated advice to ministers, the Oversight Board sought assurance from NHS Lothian that, according to its due diligence and governance, the facility was ready to open; and from NHS NSS that its agreed diligence was successfully completed.

25. The Oversight Board provided advice in relation to:
    - Advice on phased occupation.
    - Advice on the proposed solution for ventilation in critical care areas and on any other areas that require rectification works.
    - Advice on facility and operational readiness to migrate.
    - Gaining information and giving advice to NHS Lothian about commercial arrangements with IHS Lothian Limited (IHSL) for completion of works.
    - The approach to Non-Profit Distributing (NPD) contract management.
    - Identification of areas that could be done differently in future.

26. The Board membership consisted of the following persons:
    - Christine McLaughlin, Chief Finance Officer, Scottish Government
    - Catherine Calderwood, Chief Medical Officer, Scottish Government

- Professor Fiona McQueen, Chief Nursing Officer, Scottish Government
- Susan Goldsmith, Director of Finance, NHS Lothian
- Tracey Gillies, Executive Medical Director, NHS Lothian
- Professor Alex McMahon, Nurse Director, NHS Lothian
- Peter Reekie, Chief Executive, Scottish Futures Trust
- Colin Sinclair, Chief Executive, NHS National Services Scotland (shortly after replaced by Jim Miller)
- Alex Joyce, representative from NHS Lothian Joint Staff Side (deputy Gordon Archibald)

27. Also attending the Board to provide advice and assurance on matters including ventilation, mechanical matters, infection control, clinical impact and implications of decisions taken, communication and contractual challenges and negotiations, were:
    - Mary Morgan, Senior Programme Director.
    - Brian Currie, Project Director, NHS Lothian (contractual challenges and negotiations).
    - Judith Mackay, Director of Communications, NHS Lothian (communications).
    - Professor Jacqui Reilly, HAI executive lead for NHS National Services Scotland and SRO for centre of excellence work (Infection Control).
    - Gordon James, Health Facilities Scotland, NHS National Services Scotland (ventilation and mechanical matters); and
    - IHSL would be in attendance on as 'as required' basis.

28. I would also be in attendance to action any of the actual matters that needed to be done. Jim Miller also attended the early stages of the Oversight Board when we were preparing the assurance reports. Jim was technically very good and was reported into directly by Gordon James.

29. The Oversight Board provided a forum where an update on progress was reported to the Board and ultimately to Ministers. There were a number of

concurrent issues running and we were generally given a relatively high-level overview on what work was being undertaken. We would sit as a board and discuss any problems or issues arising. We would then work through them and once an acceptable solution had been found, we would report back to the Cabinet Secretary who would consider our recommendations before making any decisions requiring her input.

30. The papers to be considered at meetings of the Oversight Board were circulated in advance of the meetings. These papers included the Senior Programme Director, Mary Morgan's, report. This report covered the number of issues outstanding; numbers dealt with; and a RAG (Red, Amber, Green) status against each of the risks identified in the report. We would tend to focus on the areas Mary Morgan highlighted as problematic or challenging, for example, see the Senior Programme Director's Report within the papers for the meeting of 9 April 2020 **(A41710883 – Oversight Board Papers – 9 April 2020 – Bundle 13, Volume 4 - Page 430).**

Supplementary Agreement 1

31. I have been asked by the Inquiry regarding my understanding of the Supplementary Agreement 1. NHSL and IHSL were in dispute in relation to a number of matters which had resulted in the delayed delivery of the RHCYP/DCN project (initially scheduled for completion in July 2017). In order to advance the project towards completion, and to avoid litigation, NHSL and IHSL reached a settlement agreement. The terms of that agreement form Supplementary Agreement 1, dated 22 February 2019.

32. The Scottish Government was aware of the agreement but did not have any role in the technical assessment of what was proposed. The Scottish Government's interests in the agreement related to matters of finance and delivery of healthcare services. Accordingly, we were interested how much the agreement would cost and how the agreement would impact the timeline for delivery of the hospital. This is consistent with the respective responsibilities of

health boards and government for delivery of healthcare projects: primary responsibility lies with the health board not government.

33. The Scottish Government did not seek assurance from NHSL that the supplementary agreement would result in delivery of a hospital that complied with technical compliance with relevant healthcare guidance. At this point in time, the Scottish Government believed that NHSL had already agreed the design and construction of such a facility.

34. The Scottish Government had been briefed by NHSL on what the key issues were and what was being discussed between the parties, but it was more for background and context rather than for any technical sign-off on what was proposed between NHSL and IHSL. The key interest for us was the cost and the impact on the timeline.

35. A timeline and summary of relevant briefings sent to the Cabinet Secretary in relation to Supplementary Agreement 1 is found in Annex E of a briefing prepared for the Cabinet Secretary in advance of her meeting with staff side representatives on 9 October 2019 **(A46527556 – Briefing to Cabinet Secretary ahead of NHSL Staff Side Meeting – 9 October 2019 – Bundle 13, Volume 4 - Page 465)**. The relevant section of that briefing is copied below.

Timeline of briefings

14 March 2018 – Briefing to Cabinet Secretary highlighting there were problems with the ventilation: NHS Lothian considering court action at that point.

21 March 2018 – Briefing to Cabinet Secretary noting that court action would need to be approved by CS before it starts.

25 April 2018 – Email to Cabinet Secretary and First Minister informing both that court action is no longer being taken forward and that a loan of £10 million is being considered to allow the ventilation to be fixed.

27 July 2018 – Briefing to Cabinet Secretary noting that a loan would fail on state aid grounds, so instead a settlement agreement is now the agreed way forward.

[24] July 2018 – Paper from NHS Lothian's Finance and Resources Committee on the proposed commercial agreement between NHS Lothian and IHSL. This outlines why it is needed, what it does and what the risks are. This provides the necessary assurance for Christine McLaughlin to approve the payment.

20 September 2018 – Briefing to Cabinet Secretary detailing additional technical problems, most notably with the drainage. Highlights that 31 October handover will not be achieved.

7 November 2018 – Email to Cabinet Secretary confirming that the revised handover date of 31 October was not achieved and that a new date was still not known.

13 February 2019 – Briefing to Cabinet Secretary informing her that the Settlement Agreement was signed on 6 February 2019 and it would allow project completion to be confirmed. Three significant technical matters remain (drainage, void detectors and heat sensors) but they would be addressed post-completion and at the same time the Board undertakes its commissioning. Risks of contractor and Board working at the same time were highlighted.

The Scottish Government agreed to pay NHSL an additional £11.6m in respect of the settlement agreement.

36. NHS Scotland Assure did not exist at the time Supplementary Agreement 1 was negotiated. Were a similar situation to arise in a current development, that required the commissioning of significant works, NHS Scotland Assure would be asked to review the parties' proposals and provide the Scottish Government with technical assurance in relation thereto.

Escalation to Level 4

37. I have been asked by the Inquiry if my role had been impacted by the escalation of the RHCYP/DCN project to level 4 and whether the Scottish Government were taking more control on matters.

38. My role was not significantly impacted by formal escalation of the project to level 4. I would have had significant involvement in the project regardless of whether NHS Lothian were escalated to level 3 or 4 of the NHS Scotland Performance Escalation framework.

39. In relation to Scottish Government control, I would say that, in some respects, escalation resulted in greater government control. Escalation to level 4 resulted in Mary Morgan being appointed as Senior Programme Director. Mary was appointed to that role by the Scottish Government and had, to some extent, a controlling influence as to how the project progressed to completion.

40. However, at the point of escalation, every significant decision needed to come through, not just the Scottish Government, but the Cabinet Secretary. In that respect, the level of Scottish Governmental control was already significant prior to escalation.

41. In practice, and from my perspective, I am not sure the Scottish Government's involvement in significant decisions made a substantial difference to outcomes because there were not many occasions where NHS Lothian disagreed with any of the decisions that were being taken.

Problematic/Challenging Areas

42. I have been asked by the Inquiry if there were areas that I found most problematic or challenging.

43. What I found difficult was the technical nature of the challenges the NHS Lothian team were facing. The NSS reports set the scene, then there was

further discussion just to work through and understand exactly where the risks were and what the next steps would be to address those risks.

44. There are almost the two aspects of those risk based decisions: there are technical issues around engineering and there is consideration of what will this mean for infection control/patient and staff experience. In this respect, the balance of skill and experience of the members of the Oversight Board was a considerable asset. For example, Jacqui Reilly and Professor Fiona McQueen had a similar background and spoke the language of patient care and infection control practice. Complemented by the more technical skill of Colin Sinclair and Jim Millar of NSS. At no stage did I think that we were missing skills in any particular area. Mary Morgan's appointment, and the focus she brought to the project, was of great benefit. As was Mary's prior experience of delivering an NPD project.

45. Due to the fact that I managed the budget, or at least I needed to build any costs into the budget plan, I had been communicating regularly with three people within NHS Lothian. They were Susan Goldsmith (Finance Director); Iain Graham (Director of Capital Planning) and Nick Bradbury (Capital Lead for NHS Lothian). I was always asking them how the project was going and what they were hearing in the background. They could fill me in on where we were at with the Supplemental Agreement and what the funders were saying/when we could expect the agreement to be signed. These relationships were helpful to understand what was going on and what issues we were facing.

46. I have been asked by the Inquiry if NHSL struggled to get a contractor who was willing to take on the work with the ventilation issues. I recall that there were challenges. I was not too involved in the mechanics of identifying who was going to carry out the work. Mary Morgan, as Senior Programme Director, would be better placed to address this question.

47. In due course, Imtech were appointed to undertake the remedial ventilation works. Once they were appointed and commenced the work, it felt like everything was progressing as it should. However, at that point COVID struck

and everything was, to some extent, thrown up in the air. I discuss the impact of COVID and Brexit later in this statement.

Commercial Challenge in Negotiating Change

48. Negotiating changes to the commercial agreements between IHSL and NHSL was not straightforward. Had the project been capital funded I think the process of negotiating the remedial works to the hospital would have been more straightforward. However, Mary Morgan, who had prior experience of the NPD model, was a significant asset in bringing focus and direction to the necessary commercial negotiations.

49. Under the NPD model a Special-Purpose Vehicle (SPV) is created to deliver the project on behalf of the health board. The SPV owns the building and, in essence, leases it back to the health board. The SPV, in this case IHSL, is funded by private investors who have an interest in ensuring that their investment in the project is protected. This means that the health board and the SPV (including its funders) need to reach an agreement as to any changes that are made to the building or commercial agreements. Had the building been capital funded and thus, "owned" by NHSL, it would have, in my view, been easier to make changes to the building's design and specification. I say this because NHSL would not have required to seek the agreement, and balance the commercial interests, of the SPV. For example, I recall that there were considerable complexities related to the provision of commercial warranties for remedial works, who those warranties were owed to (NHSL or IHSL) and how those warranties impacted warranties already granted under the project agreement.

50. That is not to say, however, that the NPD model resulted in remedial changes to the hospital not being made, rather, that it seemed to take longer to get to the end result than might have been the case under a capital funding model. At the time, I do not recall that anyone stood back and thought that this would be easier if it was a capital funded build. This was the situation and we managed it.

Covid / Brexit

51. I have been asked by the Inquiry how the project dealt with the COVID pandemic. All healthcare construction projects were considered priority projects. This meant that work on those projects was allowed to continue throughout lockdown. Work practices had to be modified to protect those on site. The principal modification was socially distanced working (where possible) which resulted in less workers being concentrated in one part of the hospital at any one time. This inevitably resulted in delays because the nature of construction is that it requires a large workforce to be working in one area. For example, even something as straightforward as hanging a door requires two people. If two people are hanging a door in a room that means that others can't work around those two in a socially distanced way to carry out other tasks in the same area. Likewise, ventilation involves working in constrained spaces. The more constrained a workspace the less workers could be present at any one time.

52. The supply chain was interrupted by COVID. I recall that obtaining construction supplies was an issue at the RHCYP/DCN project and, more generally, across out network of NHS projects throughout Scotland. The lead time for sourcing materials, such as the air handling units for the critical care unit at the RHCYP increased from weeks to months.

53. I have been asked by the Inquiry if Brexit also played a part in any delays. Yes, I think that it did. It is hard to isolate delay that was caused by Brexit as opposed to COVID, however, the trade barriers, arrangements, or both, between the EU and the UK that were created by Brexit made sourcing materials from EU member states more complicated and, thus, took longer.

54. While COVID and Brexit undoubtedly delayed delivery of the project it is important, in my view, to be mindful that the RHCYP/DCN will be in use for multiple generations. At the time, there is considerable pressure to deliver a project as soon as possible, particularly where, as in the case with the RHCYP/DCN project, the existing facilities where patients are receiving treatment are sub-optimal. However, delays on large construction projects are,

in my experience, almost inevitable and are something that requires to be managed in the best possible way. Mary Morgan is immensely capable, very demanding, very driven and, from my position as attendee at the Oversight Board, I could see that the project was progressing as quickly as it could under her stewardship.

RHSC Sciennes and DCN at Western General Hospital

55. I have been asked by the Inquiry if I was aware of any of the healthcare budget being allocated to the old hospital at Sciennes and the existing Western General site, just to keep them going. When the Cabinet Secretary made the decision to delay the move to the new building ensuring that the existing treatment sites were properly maintained, through the provision of appropriate funding, was a high priority for the Scottish Government. We told NHS Lothian that if there was anything needed in the old hospitals, they were to come to us and we would prioritise it. The additional spend at these sites is set out at paragraph 21 above. Additional capital expenditure was in the region of £650,000.

56. The problem faced at the existing sites was the considerable lead time required for maintenance and improvements to healthcare buildings. For example, if you are to make remedial changes to a part of the hospital, such as a ward, you may have to plan for the closure of that part of the hospital. That means that the clinical and facilities staff have to work closely to ensure an acceptable level of continuity of service while works are ongoing. Such works are disruptive and if clinicians and facilities colleagues believe they are moving to a new facility in three months' time they will, quite properly, choose not to undertake some works that they might otherwise have scheduled. This meant that maintenance at the existing sites had been "run down" in the lead up to the proposed move in July 2019.

57. I have been asked by the Inquiry if HFS were involved in checking over anything that needed to be done at the existing sites and, if so, how was it

being fed back that changes, or amendments were required. It would have been the local estates function of NHS Lothian that would undertake that exercise. HFS' role was to provide support to NHS Boards. They were, as far as I am aware, available so that an Estates Director could pick up the phone for advice in relation to technical issues. Whether that happened with the old RHSC at Sciennes, I don't know.

58. I have been asked by the Inquiry if I was conscious of there being any concerns about the lack of air change rates at the RHSC at Sciennes being a concern for patient safety. There is a general understanding that we manage risk in our healthcare estate. We do not operate on a no-risk basis. We know that our estate is large, it is varied and a lot of it is quite old. While I am aware that the air change rates in parts of the hospital at Sciennes did not meet the standards contained in relevant guidance I was also aware that that was risk that the clinicians were capable of managing successfully.

59. Concerns about infection arising from ventilation would be directed to the Chief Nursing Officer's Directorate (CNOD) in the first instance. I work closely with the team at CNOD because if there is an infection as a result of poor ventilation, the question would be is it a ventilation issue or is it an infection issue? Rather than being caught on semantics, we would try to work together.

Cabinet Secretary Communications

60. I have been asked by the Inquiry if, apart from providing briefings from the Overview Board meetings, did I have any other contacts with the Cabinet Secretary to discuss matters. On 4 July 2019 I was one of the advisers who met with the Cabinet Secretary in person to discuss the delayed move to the new hospital. I understand that other witnesses have provided the Inquiry with evidence relevant to this meeting.

61. Thereafter, I would then meet with the Cabinet Secretary fairly regularly, along with Malcolm Wright (Director General) and Professor Fiona McQueen. I think for obvious reasons, I saw the Cabinet Secretary more than I would normally

expect to see her over that period, and occasionally she would have a specific question relevant to Health Finance.

62. Along with Malcolm, Fiona, and Christine McLaughlin, we would update her regularly. I would always try and keep briefings quite short and concise, give her the main points and then there might be a follow up conversation seeking clarification. These meetings happened more frequently in the first few months that followed 4 July 2019. However, once things were settled down and work was progressing, the Cabinet Secretary could see that there was a programme of work being delivered and naturally, this resulted in less questions coming from her. I believe that the Cabinet Secretary was briefed after every meeting of the Oversight Board.

63. I have been asked if there was a meeting with the Cabinet Secretary and representatives from Health Facilities Scotland/Health Protection Scotland (HFS/HPS) to discuss air change rates **(A34403124 - Briefing to Cabinet Secretary dated 25 July 2019 - Bundle 13, Volume 4 - Page 483)**. I am not aware if this meeting took place, or any follow up that arose therefrom. NSS or the Cabinet Secretary may be better placed to answer this question. Discussing and updating technical guidance is not part of my remit in Health Finance.

64. I have been asked by the Inquiry if reviewing NHSL board papers was general practice for the Cabinet Secretary. I am unable to answer that question. That question may be better directed at the Cabinet Secretary.

Reflections

65. I have been asked by the Inquiry if I feel that the current building, as it now stands, is safe and provides effective care for patients.

66. I am satisfied that the new hospital is one of the safest healthcare buildings in the country, perhaps, in Europe. By delaying the move the Cabinet Secretary was making sure the built-care environment was safe for the patients and staff to move into. That goal has, in my view, been achieved.

67. Delivering safe healthcare environments involves continuous learning and development. The lessons learned from the Edinburgh and Glasgow projects are being applied to our current projects. We have the Baird and Anchor in Aberdeen as our one major acute investment project that we are going for at the moment. We know that the intelligence gathered from the experiences in Glasgow and Edinburgh are feeding into the thoughts and the design and operation of the two new facilities in Aberdeen.

68. We are learning from what we are seeing in terms of infection risk. For example, we are learning more about the consequences of moving to the presumption of single occupancy rooms.

69. All new facilities have a presumption of single room provision. This means that each room has its own bathroom facilities. This is great from a patient dignity point of view but means there is more bathroom furniture (sinks, taps, showers, toilets). The more sinks there are the less frequently each one will be used. This increases the risk of stagnant water build up in taps etc and thus, the risk of infection. One of the things that colleagues at NHS Grampian are clearly communicating with their colleagues in Glasgow and Edinburgh, is, “Well, do we need a sink in this place?” Some of this may seem mundane but the consequences of not learning these lessons can be severe.

70. We have a better understanding of fire safety now than when we started the RHCYP/DCN project. The intelligence that goes into the design of a new hospital reflects all the learning from past projects (including maintenance of existing buildings).

71. The patient environment is much better at the RHCYP than at the RHSC at Sciennes. For example, the accommodation for families is much better: there is a 24 bedroom unit for families to stay at the RHCYP. This is in stark contrast to the lack of bespoke facilities for families to stay overnight at the old RHSC.

72. I am a finance professional not a clinician or technical expert, but I am confident that the new hospital will be providing a safe and very thoughtful and patient-centred healthcare to the children and families that have to use it.

73. I have been asked by the Inquiry if I feel that anything could have been done better or differently. It would have been much better if the misspecification of air change rates in the critical care unit at the RHCYP could have been identified earlier so that the facilities were not designed and constructed to deliver air change rates that did not comply with the appropriate guidance. However, I would not have changed what the Scottish Government did, or how it, or I, or both acted once we were made aware of the issue.

74. Managing healthcare budget and thus, the maintenance of existing facilities, or building new facilities, or both, is not straightforward. There are two clear challenges. The first is financial and everyone understands that because upgrading facilities is expensive. The second is that our hospitals are busy. Occupancy rates vary across the site, but it is not uncommon to see facilities with an occupancy rate of 90 plus per cent. The question is, if you are going to upgrade a ward or a theatre, where do the patients go that would be in that ward normally? Or if you take theatres offline to improve the ventilation, what happens in that patient capacity?

75. If a ventilation system at an existing site is not compliant with existing guidance, that would not in itself make me think, that we need to rip it out and put in a new one. I would question what the risk was, whether there was any sign of infection or adverse impact from a non-compliant ventilation system and manage risk appropriately (either by maintaining the status quo or installing a replacement/upgrade).

76. The change in the last four years, again whether it's COVID, Brexit, or Ukraine, has resulted in the cost of a new hospital increasing on an exponential basis and, if you replace a hospital, it is very, very expensive.

77. We need to manage risk and that can be really difficult to get that message over because it can be, “So what are you saying, are you accepting that patients are at risk in some facilities?” Whilst that is not the case, infection does happen in hospital. We have to consider how to minimise that at the macro level and to ensure that we are treating as many people safely as we can. It is a real challenge to maintain our Estates.

Declaration

78. 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.