SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
26 February 2024

Day 10
Tuesday, 12 March 2024
Jeane Freeman

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10:03

THE CHAIR: Good morning. Now, Mr MacGregor, I think we are ready to recommence with Ms Freeman.

MR MACGREGOR: Yes, my Lord. Good morning, Ms Freeman.

THE WITNESS: Good morning.

THE CHAIR: As you understand, you are about to be asked questions by Mr MacGregor, who is sitting opposite you, but, first of all, you are agreeable to take the oath?

THE WITNESS: Yes, I am.

Ms Jeane Freeman

Sworn

THE CHAIR: Thank you, Ms Freeman. Now, as has probably been explained to you, we will be sitting between ten and a lunch break at one. We usually take a coffee break at about half past eleven, but, if at any stage, you want to take a break for any reason, just give me an indication. Mr MacGregor?

Questioned by Mr MacGregor

Q You are Jeane Tennent Freeman. Is that correct?

A I am.

Q And you have provided two witness statements to the Inquiry?

A Yes.

Q Just for the benefit of core participants, the first statement is at pages 160 to 214 of bundle 1 of the witness statements and then the second witness statement is at pages 12 to 19 of bundle 4 of the witness statements. Ms Freeman, the witness statements will form part of your evidence to the Inquiry, but you are also going to be asked some questions by me today. Copies of your statements should be available, so if you do want to refer to them at any point, please just do let me know. If there is any documents that I wish to take you to, those should come up on the big screen in front of you. If for any reason you cannot see them or cannot see the part of the document I am referring to, please just do let me know.

A Thank you.

Q I would like to begin just by asking you some questions about your qualifications and work history, which are set out within your statement. You will appreciate that really for the purposes of today it is really the period of your career where you were the former Cabinet Secretary for Health and Sport that the Inquiry is interested in, but before that am I

correct in thinking you trained as a nurse initially?

A I did, yes.

Q You joined the Civil Service in 2000?

A Yes.

Q You were appointed to the Board of the National Waiting Times Centre, a special health board that runs the Golden Jubilee National Hospital in 2008. Is that correct?

A Yes.

Q And in 2011 you were appointed as chair of that Board?

A Yes.

Q So in addition to your experience as former Cabinet Secretary for Health and Sport, you also have relevant experience as the chair of a health board for a period of time?

A I do.

Q And, again, we will come on and perhaps chat through some of the detail of that, but how relevant was that experience whenever you were coming to make some of the decisions in relation to the Royal Hospital for Children & Young People and the Department for Clinical Neurosciences?

A Well, it certainly formed part of the experience that I brought to that decision-making because Golden Jubilee Foundation is a national board, so it offers services across the whole of Scotland, and that means that there is an interrelationship with the territorial boards, for example, NHS Lothian is one. So I was familiar with the work of territorial boards and the work of my colleague chairs from those boards, as well as the work I did myself with Golden Jubilee.

Q Thank you, and you stepped down from the Board in 2016 when you were elected as a member of the Scottish Parliament. Is that right?

A Yes.

Q And you were the Cabinet Secretary for Health and Sport between 2018 and 2021. Is that correct?

A Yes.

Q And, again, perhaps just to reference matters in terms of what I will call the project, the Royal Hospital for Children & Young People, and the Department for Clinical Neurosciences, at the point that you are appointed as Cabinet Secretary, the project agreement has already been entered into and there are detailed construction works that have already taken place. Is that correct?

A That's correct.

Q Thank you. In terms of

your evidence today, there are really six matters that I would like to explore with you. The first is really just to ask you some general matters about the project. The second issue would be to discuss a timeline in decision-making up to 4 July when you make the decision not to open the hospital.

The third issue would then be to look at some of the problems with the project and why the hospital could not open. Fourthly, then, to look at remedial works and the decision to open the hospital, and then topics five and six would be to ask for some of your views on NHS Scotland Assure, the centre for excellence, and then any other reflections that you have on the project. So, we will deal with some general matters and then look at some specific matters thereafter.

So, in terms of general matters, in your position as Cabinet Secretary for Health and Sport, you explain within your statement that that would be a strategic leadership role. It is about holding boards to account, but the overriding responsibility is to ensure the safe and effective delivery of health and social care in Scotland. Is that right?

A That's correct.

Q And within your statement, I will not take you to it at the minute, but at page 167 on paragraph 26 you describe health boards as being the delivery arm of the NHS. Could you perhaps just explain to the Inquiry, what do you mean by that? How is there a division between the Cabinet Secretary and the Scottish Government on the one hand, and the health boards on the other?

A So, the Scottish Government through the Cabinet Secretary for Health sets the strategic direction for the NHS in Scotland and makes decisions about the overall resourcing of those. You don't do that in isolation. You do that with input from your clinical advisors, and indeed from our royal colleges and our healthcare unions, and the views of particularly Board chief executives, but you set the overall strategic direction.

Your responsibility is then to resource that as best you can, and it is the job of health boards, whether they're territorial or national, to deliver against that overall strategic direction, but they also have a responsibility to be able to deliver what is being asked of them in the knowledge of the local circumstances of the area that they are responsible for. So, for example, you would expect the delivery of a particular area of healthcare, perhaps primary care, perhaps specialist care

to be different in an area like NHS Highlands, where not only the population but the spread of population, the distances between areas of population is significantly different from what you might find in the Central Belt. The same would be true of Dumfries and Galloway or the Borders.

So, they need to understand their local area and the opportunities and constraints that that poses and look to ensure that how they deliver makes sense for their own area. So they might not all do it the same way, but they should all be pointing in the same direction, if you like.

Q Thank you, and in terms of major projects, if we are thinking about a major new-build hospital, what is the division between the involvement of central government as opposed to the Health Board?

A So, the Health Board is the statutory body responsible for the delivery of a build project. It will identify where it believes one is needed, put together the argument to support that, and approach Scottish Government for agreement on, if you like, its business case and therefore the funding resource that is likely to be required. And it will argue, as any health board should, that its particular project is important, and try and argue to have agreement for it to go ahead in an early round of capital funding, where there is the option of capital funding from-- So I think it was being referred to earlier in the Inquiry as treasury funding through government.

Now, in getting to that point, the Board will have had a number of discussions with officials in the Health Directorate, partly around whether capital funding is an option, and if not, what the alternatives might be. They will involve Scottish Futures Trust in that, in looking at what other funding options there might be, but they are in the lead for that.

And government's job and the Cabinet Secretary's job is to determine whether the case for that new facility is made and whether or not there is a sufficient resource package there to allow that to happen, but the Health Board is the lead body, the statutory lead body.

Q Thank you, and if I could perhaps just ask you to look to your statement, please, which is in bundle 1 of the witness statements, to page 166 and to paragraph 23. So, page 166, paragraph 23. You see the sentence beginning, "As Cabinet Secretary…"? Do you see that?

A Mm-hmm.

Q So, you tell the Inquiry:

"As Cabinet Secretary, the starting point in relation to any NHS project was for me to be assured, at the highest level, that projects being run by the health board were progressing on time and within budget. It is not the role of a Cabinet Secretary, generally speaking, to be involved in the day-to-day progress and decision-making on any project commissioned and being managed by a local health board."

Do you see that?

A Yes.

Q So, if the project has been approved for funding and is on time and on budget, is it very much a hands-off role from central government?

A Yes, it is. The government would expect to be kept up to date with how it is progressing and certainly to be alerted to any particular issues, either in terms of the financial envelope that's been agreed or glitches in the progress against the timeline.

Q Okay, and how serious does an issue have to be with a project before it would be escalated not just to civil servants within the Scottish Government but right up to the Cabinet Secretary?

A So, an example of that would be that there was a point not long after I was appointed as Health Secretary where I was briefed to a situation with this particular project and the Board where there was a possibility of court proceedings. So, obviously then, that's an indication of the level of seriousness that would mean something would be-- I would be alerted to it. I'm then-- You know, with all the background to that and so on, and I'm then kept up to date with whether or not a resolution has happened, in this case, could be found.

Q So, if we think about a project that there is some form of trouble or some form of distress, once it comes onto the radar of Scottish Government and potentially the Cabinet Secretary, how involved would the Scottish Government be at that point? Is it simply wanting to keep a watching brief on things, or would there be direct involvement from that point onwards, or does it simply depend?

A I think it depends. As a Cabinet Secretary, you are reliant on the judgment of your senior officials in the Health Directorate, most

importantly the chief operating officer, but also your director general, as to whether or not, A, to alert you to an issue, and, B, to then offer a view and advice as to whether or not they think government should be more directly involved.

Now, there will be direct involvement, for example, if there is a financial issue or, as I have just explained, the possibility of court proceedings between a board and another party, but you are reliant on that advice, and oftentimes what you're being told is that you don't need to do anything as the Cabinet Secretary, but you need to know what your officials are doing. And they may be appointing a board or advising a board to approach Scottish Futures Trust, or Health Protection-- yes, Health Protection Scotland, or one of the other bodies that has expertise and advice.

Q Okay, and if we just think to the role of the Cabinet Secretary, there is a project whereby there is a problem. It is in some form of distress. Am I right in thinking that you would be wanting some form of assurance that that project is taking steps to get back on track?

A Oh, absolutely, because in all of this, of course, what we have to remember is that as Cabinet Secretary, I am accountable through the Scottish Parliament to people in Scotland for the safe and effective delivery of healthcare. So whilst it may be the case on occasion that officials advise me of a situation and advise me about what they're doing, that doesn't mean that I am a passive recipient of that advice.

I may ask them to do something in addition to what they're suggesting. I may talk to them about whether or not I should intervene, even if that is only to raise the matter directly with the chair of the Board, whom I or my predecessor will have appointed. So the Cabinet Secretary is not a passive recipient of this information, even if they do not have a direct-- or they do not decide to directly intervene.

Q So, if there is a problem that arises, there would have to be a solution and some form of assurance provided to Scottish Government and Cabinet Secretary before the project can go further down the line.

A Yes, yes.

Q Thank you. I would now like to just ask you some general questions about the Royal Hospital for Children & Young People, and the Department for Clinical Neurosciences. We will come on to

the detail later in your evidence, but the hospital does not open as planned on 9 July 2019. Is that correct?

A That's correct.

Q And that is because you take a decision on 4 July that it should not open. Is that correct?

A Correct.

Q Okay. If I could ask you to look to your witness statement, please. So bundle 1, page 176, and to paragraph 52. So, you tell the Inquiry:

> "We were aware that in the background there were issues with the QEUH, but primarily it was about patient safety."

Do you see that?

A I do.

Q So, could you just explain, in broad terms, why did you determine that the hospital could not open?

A Because I could not be assured that it would be a safe environment to put patients and staff into. Not only because of the issue around ventilation that had been raised with me, but also given that we were being advised of that so late in the day, with very few days before the planned opening, then I was anxious about whether or not there were any other areas, critical areas, to effective functioning of a hospital environment that might also not be meeting standards.

Q Okay. So, concerns about ventilation, but it is not just concerns about ventilation. You have got the concerns about ventilation, but at this point you are thinking, "Are there other things that are wrong with that hospital?" Is that right?

A Yes, that's right. I mean, I think reasonably, if you're told on 4 July that there is-- or you're told on 2 July that there is a critical issue with ventilation in critical care, and in critical care at that point, subsequently wider, but in critical care, and the hospital is due to open to much fanfare on 9 July, I think it is reasonable to say, "Well, what else don't we know? And if that bit is not safe, then how can we be sure that any other part is safe and has met"-- and by that I mean has met standards.

And the point about, in the background, there were issues with-- we were aware-- I was aware there were issues with the Queen Elizabeth University Hospital, was my knowledge of the problem of trying to fix an important matter that relates directly to infection prevention and control whilst you have patients in situ, and the risks that that in itself carries.

Q So, you have got the

embedded knowledge from the Queen Elizabeth University Hospital.

A Yeah.

Q A hospital opens, and then you try to retrofit it.

A Yeah.

Q You know that that is an incredibly difficult thing to do. You are told that there is issues with the critical care rooms, but you are saying it is not just about critical care, but in terms of the critical care rooms itself, I would just like to understand what your thought process was at the time. Was your position that the critical care rooms were not safe, the ventilation system was not safe for patients to enter?

A Yes, that was my position. My understanding was that the air change was 4 per hour and the standard requires 10 per hour, so we weren't even halfway there.

Q So, again, just so I am understanding things, the guidance, which we will come on to talk about, Scottish Health Technical Memorandum 03-01, says 10 air changes per hour for critical care. The testing shows that it is 4 air changes per hour. Your understanding as Cabinet Secretary was it does not comply with the standard, and if it does not comply with the standard, it is not safe. Is that correct?

A That's correct.

Q In relation to the guidance, Scottish Health Technical Memorandum 03-01, the Inquiry has heard a lot of evidence that it is just guidance. This was not a hard-edged legal standard set out in a set of regulations like the building regulations. At this point in time, were you surprised that that type of information that you attributed to patient safety was simply set out in a guidance document, as opposed to some sort of hard-edged legal standard?

A Not especially, although in truth I'm not conscious that I worried about that in particular. As far as I was concerned, the guidance is produced by people who are expert in the field for which the guidance addresses. If you have that guidance – it's advising you of best practice – why would you not then follow that? Whether it is mandatory or not, why would you not do that? How could you possibly justify not doing it?

Q So, again, just so I am understanding matters, is this really a policy decision on the part of Scottish Government and yourself as Cabinet Secretary that you have the published guidance that sets standards and that

patients in Scotland are entitled to expect that they would be treated in a new-build hospital that complied with the guidance that sets up-to-date safety standards?

A That's correct, yes.

Q Again, should the Inquiry understand that if there was a new-build hospital that did not comply with those standards, the Scottish Government would want that hospital to be retrofitted so that it did comply with that standard?

A We would want the compliance with the standard fixed. Now, whether that is retrofit, or whether that is resolved and improved to standard before the new build opens depends on what's involved in fixing, whatever the problem is, to meet the guidance.

Q Again, just so I am understanding things, that is because, I think as you said earlier in your evidence, when we are talking about the guidance, yes, it is just guidance, but really in your position as Cabinet Secretary, you are equating a compliance with the guidance with a safe hospital.

A Yes, I am. That is partly because, as I've said, guidance is drafted by those who are expert in the area that the guidance addresses. I'm a Cabinet Secretary. I'm not an expert in infection prevention and control. I'm not an engineer. I'm not a construction expert. So it is important that I pay attention to the expertise in the relevant field and don't try and gainsay it.

Q Thank you. The final, just general, very broad question that I would ask you at the outset of your evidence: you have this project which is late, over budget, all the implications that come with that. What went wrong so that the hospital did not open on time and on budget?

A So, my understanding, from the reports from both KPMG and NSS that I commissioned, is that the root here is a human error between the specification and the Environmental Matrix that was not then picked up subsequently at any of the points where it might have been identified and fixed. So the mistake was bedded in then, and it was not until the very last minute when the ventilation was tested that the problem was discovered.

Q Okay, so your understanding, given all the reports that have been done, investigations that you will have undertaken, is there is a human error right at the start of the project that effectively gets hardwired

in and just is not spotted at the various stages through the project. Is that right?

A Yeah, and that it isn't spotted at various stages of the project is actually an important point.

Q Mm-hmm.

A So, we're looking at a situation where a mistake is made, and human beings make mistakes, but the point of governance, which is about scrutiny and challenge is, amongst other things, to identify where mistakes might have been made and through scrutiny and constructive challenge, address those and resolve them. So in my view, that process also did not work.

Q Mm-hmm, and, again, I would be interested in your views. The Inquiry has heard a lot of evidence that NHS Lothian did not have the technical skills in-house to try to manage this type of project. So they have lead technical advisors, engineers that get appointed externally. They have a set governance procedure that complies fully with the Scottish Capital Investment Manual. Standing back from matters, how did it come to be that none of the advisors spot any of these issues and none of the governance structures spot these issues?

A So, in terms of the advisers, I can't comment on that. I'm sure that you will have addressed those relevant questions to them. In terms of the governance, there is an issue around governance in my opinion, and that is you can have governance structures, so you can have the bit of paper that sets out very clearly which committee is where and who does it report to and so on, but governance is a proactive exercise. Governance requires to be a verb as well as a descriptor. So if in your governance structures, those responsible are not questioning, or you do not have all of the expertise into that governance structure that you need, then the risk is that you miss important matters and they, as we've said, just become bedded in.

Now, NHS Lothian, as you've said, had advisors and technical expertise, but in-house they also have expertise in infection prevention and control. They have very senior, very well respected, very experienced clinicians who know what they expect if they're working in a critical care unit, and they expect the standard of 10 changes per hour to be met. So you have to involve those individuals in the design and the governance of delivery in the same way as you involve

engineers, construction experts, whatever else it might be.

Q Thank you. I would now like to move on to the second broad topic that I would like to explore with you today, and that is really a timeline and decision-making, considering the period really from 2018, whenever you come into office, right up until 4 July 2019. Before you get appointed as Cabinet Secretary, there is an ongoing dispute between NHS Lothian on the one hand and the Project Company and its subcontractor, Multiplex, on the other. It is about approximately 20 rooms and primarily about what the pressure regime should be in those rooms – should it be balanced or negative pressure, or should it be positive pressure? Whenever you were appointed as Cabinet Secretary, does this come onto your radar? Are you briefed about this ongoing dispute?

A So, I am briefed about that ongoing dispute, and that is what I referred to earlier where at the point where I was briefed, there was a possibility, if no resolution could be found, that there would be court action. So part of the rationale-- I mean, I would be briefed, in becoming Cabinet Secretary, on a range of different running matters, if you like, across health and social care, but in this particular instance it was focused around the dispute and the options at that point, either a resolution, or there would be court proceedings.

Q If there was going to be court proceedings, albeit they would be in the name of NHS Lothian, would they have to be raised with the knowledge and approval of the Cabinet Secretary?

A No, they would not require approval of the Cabinet Secretary because NHS Lothian is a statutory body responsible for the build for that project. I would expect them to be raised with the knowledge of the Cabinet Secretary, but a Cabinet Secretary would not be asked to approve that.

Q Okay. If I could perhaps just ask you to look to a briefing note that was made available on 9 October 2019, so that is bundle 8, page 109. So bundle 8, page 109. It was a briefing note for a staff side meeting, but there is quite a bit of embedded background documentation in relation to that briefing.

THE CHAIR: Thank you.

MR MACGREGOR: If I could ask you to look on to page 119, please, and it is to the timeline of briefings. These are briefings that take

place slightly before you come into office, I think, in the summer of 2018. You will see approximately in the middle of the page, there is an entry for 21 March 2018. Do you see that?

A Yes.

Q Where it says:

"Briefing to Cabinet Secretary [which would be the previous Cabinet Secretary] noting that court action would need to be approved by CS before it starts."

Do you see that?

A I do.

Q Your understanding is that that is not technically correct, that NHS Lothian could litigate without the approval of the Scottish Government?

A Yes, that would be my understanding. The reason I have that understanding is because of a situation with Greater Glasgow and Clyde on a completely different matter, nothing to do with a build but to do with mental health actually, where that health board was considering court action, and it was not my job to approve it. So that's the basis on which I do not believe it would be the Cabinet Secretary's job to approve it, unless there was additional financial pressures as a consequence of that, which the Board did not believe they could meet themselves within their budget.

Q Thank you. The Inquiry has heard a lot of evidence about this dispute and how it comes to be resolved. The broad thrust of the evidence before the Inquiry is that there is a principals meeting that takes place in the February of 2018 that does not resolve matters. There is the possibility of litigation in March/April. There is discussions that continue. It is not clear when there is actual agreement that is reached, but approximately summer 2018, at which point Project Company and their subcontractor, Multiplex, carry out the works to achieve balanced or negative pressure, albeit the formal agreement, the Settlement Agreement, is not signed until the February of 2019. Is that your understanding of the chronology of events?

A It is, it is, and that agreement of course required approval from government because it required additional funds.

Q Mm-hmm, and could you just explain to the Inquiry, in that period through late 2018 up to the point that the agreement is signed and the funding is put in place by the Scottish Government, what is your involvement in relation to that

process?

A I don't really have any involvement in relation to that process, given that the board is the statutory body, agreement has been reached. My involvement, if any, is to understand from Health Finance what the impact might be of additional funds being made to NHS Lothian to pay for the settlement, if you like, what the impact of that will be on the rest of the health budget. In other words, what might we not be doing now because we need to put money in that direction?

Q Okay, and what assurances, if any, would you be seeking as Cabinet Secretary that this was a good deal that was going to get matters back on track?

A So, I would look for, excuse me, assurances that, exactly that, that it-- that that was worth spending that money on, and those assurances would come largely by saying, "Well, the alternative is court action, which will produce delays, potentially cost significantly more money," and so a resolution is always better than going down that route. The detail of the resolution, I would not expect to know, but I would assume that the Board as a statutory body with all its responsibilities for the build would ensure that the resolution allowed the build to progress to the required specification.

Q Okay. So, when we are talking about assurances being provided to the Scottish Government and to the Cabinet Secretary, if the Health Board is saying, "We have reached a deal and matters are going to get back on track," you would simply assume that that should be taken as read that it will resolve the dispute?

A Yes. Now, government officials will have a lot more detail behind that, but there really isn't any point in having a Health Board as a statutory body responsible for a build if you are not going to trust that they are able to meet the responsibilities placed on them, and when they give you that assurance at the highest level in the Health Board, which would be the chief executive, who themselves, you assume, has been assured of the matter, then it is reasonable to trust in their judgment.

Q You do not think that is problematic when a project is in distress, that a Health Board has already got into problems and they then simply say, "We need more money and we have reached a resolution and it is all going to be fine," you do not think, at that point, central

government should be asking for more in the way of assurances?

A So, I don't think it was quite as you've categorised it. I think the Health Board would argue that the dispute was not solely of their making and that they needed to resolve that with the Project Company and then, through them, with the contractors, and that when they come back and say, "We have now reached a resolution on these matters in detail but we need additional funds from Scottish Government," then Health Finance in Scottish Government would be looking at, "Why do you need extra money? What's it for and what areas of resolution? Is there anything outstanding?" So they would have those assurances and their advice to me or their briefing to me would be, "A satisfactory resolution has been reached."

Q Do you think, at this point, before the Settlement Agreement was reached with changes to the technical specification, that Health Facilities Scotland should have been instructed to review the technical solution contained within the agreement?

A Well, I think, if NHS Lothian did not ask Health Facilities Scotland to review that, then that's a miss.

Q So, if there has not been a review by Health Facilities Scotland, that is "a miss", as you describe it?

A Well, as I understand it, that Settlement Agreement involved derogation from standards. Now, I would have expected derogation from standard to be advised to Scottish Government. My understanding is that that was not the case, and I'm confident it wasn't the case because that would have come to me, and, again, there would have been an opportunity at that point to intervene, certainly before more public funds were used, but the Board did not advise Scottish Government of that and, again, as I understand it, did not seek Health Facilities Scotland's input.

Q Yes. I will not take you to your statement but just for the Chair's notes, at page 169, at paragraph 30, you make the point that you were not aware that Settlement Agreement 1 involved compromises to the ventilation system or any deviation from normal guidance. Is that correct?

A That's correct and I am confident that Scottish Government was not aware.

Q Were you aware that, in terms of the negotiation of the Settlement Agreement, that there was

no involvement from the lead infection prevention and control doctor or the lead infection prevention and control nurse at NHS Lothian?

A No, I'm not. I would have expected such involvement.

Q So, does that surprise you that there was not that infection prevention and control input onto a revision to a technical solution for a system in critical care areas?

A It does surprise me, and I think it is a mistake. Any built environment that is there to deliver healthcare should have all necessary and appropriate measures for infection prevention and control built in, from design all the way through.

Q And do you think Scottish Government should have checked whether there was infection prevention and control input or is that back to the point that you made earlier that, as Cabinet Secretary, you need to trust the health boards to get on with delivering these projects?

A So, that was the situation, is exactly as you've described. I know we will come onto NHS Scotland Assure later in this session, but part of my thinking about why we needed such a body was precisely to ensure that infection prevention and control is baked into the design, the business case, the construction, the assurance of standards and the delivery of healthcare.

Q Thank you. Were you aware, whenever Settlement Agreement 1 was being approved in the February of 2019, that it involved the building being accepted and handed over to NHS Lothian with the stage payments, the £1.4 million per month, starting immediately when the agreement was signed?

A Yes, I was aware of that, yeah.

Q And why was the view taken that that was appropriate?

A My understanding is that that was part of the agreement, that the remediation that was agreed in the Settlement Agreement was accepted by the Board as constituting appropriate handover and, of course, at handover, they then become liable for the payments.

Q One of the areas that the Inquiry has heard quite a lot of evidence about is a procedure called the HAI-SCRIBE procedure. Have you heard of that, perhaps----

A I have, yes.

Q -- after the event at some point? And the way it was explained to the Inquiry by Dr Inverarity, the lead

infection prevention and control doctor at NHS Lothian, was that he had no involvement in the Settlement Agreement. He simply found out by an all staff email that the building had been accepted, NHS Lothian had accepted it, and he was extremely concerned at that point because what he described as the "Stage 4 HAI-SCRIBE check" had not been completed before the building was accepted, and his evidence was that the Stage 4 HAI-SCRIBE check is effectively the final safety check, and it should be carried out before a health board accepts a hospital. If you do not do it, you do not know that the hospital that you are accepting is safe.

Do you remember any discussions taking place around about Settlement Agreement 1 as to whether the Stage 4 HAI-SCRIBE would simply either be skipped or pushed down the road?

A I don't recall that, although what you've recounted Dr Inverarity said makes perfect sense to me.

Q Again, it might seem surprising to a layperson that the Scottish Government is providing funding for a Settlement Agreement which involves a new-build hospital being accepted at a point where the Stage 4 HAI-SCRIBE has not been completed. How did that happen?

A Well, firstly, I don't know whether or not Scottish Government knew that the Stage 4 HAI-SCRIBE had not been completed, and I go back to the point that the Health Board is the statutory body responsible for this building, and so it is reasonable to expect that they have gone through all the necessary steps.

Q Is that not something the Scottish Government should be checking, though, saying, "You are accepting the building and we are giving you the money for it. Have you followed and completed the Stage 4 HAI-SCRIBE?" Should Scottish Government not want that check or balance before they provide the money to the Health Board?

A So, one part of me agrees that that should be the case, but there is an argument put that for Scottish Government to take on that role is to compromise the legal standing of a health board and the statutory responsibilities and roles that it has. That is a bigger question across a number of areas than simply in this case and I think it is a legitimate area for future discussion.

Q And, again, I think this is something you pick up towards the

end of your statement, but it would be helpful to understand your thought process both as someone who has sat on a board and also someone who has held office as Cabinet Secretary, but you have a project that, by this point, is in some distress. You mentioned that there would come a point in a distressed project where Scottish Government and the Cabinet Secretary may need to take a more active role. Could you just explain why you thought, in this particular project, the money could be handed over, but the Scottish Government did not need to take that more granular role in the project and the approval processes?

A I'm not sure that I did think that. That was the way it had always been done. The advice to me was, of course, because of the statutory nature of the Board and therefore their responsibility for the build, it was entirely appropriate to assume, based on their assurances, that they had taken all the appropriate steps before they accepted handover, and the government's role in all of that was one step removed and largely on the basis of financial arrangements.

The monthly payments were already built into NHS Lothian's budget, so there was no questioning around that, and if-- Scottish

Government's position was, if the Board was satisfied that it was prepared to accept handover, that was for the Board to make that decision. There is, of course, an obvious follow-on question, which is, "If you were starting from a blank sheet of paper, would you do it that way again?" If I had that blank sheet of paper, no, I wouldn't.

Q So, if you had that blank sheet of paper, what would you do to try to improve and tighten up those governance procedures?

A So, I think the establishment of NHS Scotland Assure was my attempt to walk the tightrope between the position of health boards in terms of their legal standing and statute and what I consider to be the responsibilities of Scottish Government and a Cabinet Secretary. So, without throwing up in the air the legislation that underpins health boards, with all the furore and time that that would involve, NHS Scotland Assure, in my mind, was the means by which Scottish Government could have – independent of a health board, to a degree independent of Scottish Government – levels of assurance across a range of matters greater than had been the case up until that point.

Q Would you agree, looking

back, that if the Scottish Government were going to fund a health board to the point that it was entering into a Settlement Agreement to accept a hospital and begin making the stage payments for the hospital, that it should, in the future, seek assurance that standard procedures, due process, including the HAI-SCRIBE process, were fully completed before that took place?

A So, I think what Scottish Government, in this particular instance and in others, sought assurance was it all-- probably framed-- I mean, I don't know this, but it would probably be framed in terms of, "All required steps have been taken", and what you're suggesting is that we have a bit more granular detail behind that phrase. So Scottish Government would have sought assurance, "All appropriate steps had been taken by the Board," and if the answer to that is yes, then proceed. To have more granular detail behind that question, I think would be reasonable.

Q Thank you. The Inquiry has heard quite a lot of evidence about the financial position of the Project Company, IHSL, in the period late 2018 to February 2019. The evidence indicates that the company was in a degree of financial distress, potentially

looking at insolvency, because it was a project company set up that had debt to fund, but none of the staged payments had started coming in. Do you remember any discussions taking place in relation to the financial position of the project company, IHSL, in the period late 2018, into early 2019?

A None that involved me. That doesn't mean they weren't happening, but they did not involve me.

Q Okay. The reason I raise that is in submissions to the Inquiry, NHS Lothian describes what happens in February 2019 as a bailout. It was money to bail out the project because the project company was on the verge of insolvency. It sounds from your evidence that you were not aware of that type of analysis at the point that you were being briefed in early 2019.

A No, I wasn't.

Q If, as a matter of fact, the project company was staring down potential insolvency, does it surprise you that you were not aware of that fact in either late 2018 or early 2019?

A Yes.

Q And, again, presumably it follows then, that that is the type of issue that you would expect to be escalated not just into Scottish

Government, but right up to the Cabinet Secretary?

A Well, it is a material factor, I would have thought, in the case to approve the additional funding to support the settlement.

Q So, should the Inquiry understand that once that Settlement Agreement is approved, the money moves, the staged payments are starting to be made, as far as you were concerned as Cabinet Secretary, this project was effectively back on track and it did not at that stage need further direct involvement from Scottish Government?

A As far as I was concerned, it was back on track and I would expect my officials to continue to be kept up to date about its progress.

Q Thank you. Just at this stage, so we are not moving out of the sequencing in the chronology, NHS Lothian sought assurances from the project company in relation to compliance with published guidance, including SHTM 03-01, in early 2019, and I will just ask you to look at that that letter, please. It is in bundle 4, page 9, and it is a letter from IHSL to Brian Currie on 31 January 2019. Do you see that?

A Yes.

Q If we look over the page, onto page 10, the reason that that timing could be quite important is it is in sequencing before the Settlement Agreement is signed, but it is after the works have actually been completed in 2018. So the tweaks have been made to the ventilation system in 2018, this letter comes in, in early 2019, and then the Settlement Agreement is signed in February, but there is not any material changes to the ventilation system after this letter is written. It is just the section on page 10. So on page 10 it states:

> "All critical ventilation systems inspected and maintained in line with 'Scottish Health Technical Memorandum' 03-01: Ventilation for healthcare premises'
>
> Construction: - All ventilation systems have been designed, installed and commissioned in line with SHTM 03-01 as required, systems are maintained in such a manner which allows handover actual completion to meet SHTM 03-01 standards.
>
> Operations: - All critical ventilation systems will be inspected and maintained in line with 'Scottish Health Technical

Memorandum 03-01: Ventilation for healthcare premises."

Do you see that?

A Yes.

Q Do you recall having seen this letter before?

A No.

Q Okay. The reason I raise it-- and it is perhaps looking at matters through the lens of whenever you used to sit on the National Waiting Times Centre Board, but also as Cabinet Secretary. It seems from this letter that NHS Lothian both sought and received assurances from the project company that the ventilation system, as installed, fully complied with SHTM 03-01. We can talk about the granular level of detail on the project, but from a governance perspective would you have expected NHS Lothian to do anything more than seek that type of assurance?

A Well, it depends. I would've expected NHS Lothian to have independent assurance, not simply from the company itself.

Q Okay, and should that independent assurance have come before the Settlement Agreement or perhaps at a later stage before the hospital opens?

A No, I think it should have come before the Settlement

Agreement because at that point they're accepting a handover and you're accepting that the necessary steps have been taken. Now, you might have assurance-- independent assurance of a number of issues and agreement that outstanding issues will be resolved following handover – that's possible – and then some caveat around the further issues to be resolved, requiring independent assurance that they have been. So that's possible. I could see a situation where that might be a reasonable agreement to reach with the project company, but I would expect independent assurance.

Q And in terms of that independent assurance, the Inquiry has heard evidence that the technical schedule to the Settlement Agreement, so the part that says balanced or negative pressure, not positive pressure, that was drafted by NHS Lothian's lead technical advisors, Mott MacDonald. Would you have expected a further tier of independent assurance to have been provided to NHS Lothian or do you think it would have been acceptable simply for them to rely on the external lead technical advisors that they had engaged?

A I think it would be reasonable for them to rely on the

external advisors.

Q Thank you. I would like to just focus on this time period again, so late 2018 into early 2019. Were you aware of potential issues emerging at the Queen Elizabeth University Hospital in relation to water and ventilation in this period?

A Yes.

Q And, again, this leg of the Inquiry is to deal with the Royal Hospital for Children & Young People and the Department for Clinical Neurosciences. So I will ask you some questions today about the Queen Elizabeth University Hospital. That is really just to put in context decision-making in relation to the Royal Hospital for Children & Young People. The detail of the Queen Elizabeth University Hospital, what may or may not have been wrong with that hospital, is for another day, but it is really just to understand what you were being told and what you understood as-- let us just call them emerging issues at the Queen Elizabeth University Hospital. What was your understanding?

A So, my understanding, and I may not be – because I don't have the information in front of me – absolutely correct in terms of any timeline, but my understanding was that there were issues with the Queen Elizabeth University Hospital in terms of water and whether or not the water and drainage systems were producing bacteria that could cause infection. That, I think, at that particular time at the start-- end of 2018, start of 2019, would be my understanding. Of course, subsequently – and I can't quite recall when exactly it happened – the situation at Queen Elizabeth with respect to pigeon droppings, when that occurred and I visited the hospital and then I became much more aware of all the detail around what were the issues there, what were the different views around that, and then subsequently around the situation with respect to the Haemato-oncology Unit with Children & Young People.

Q Thank you, and perhaps just to put that in context, if I could ask you to look to bundle 4, please, page 8. This is a letter-- Scottish Government headed letter paper, on 25 January 2019 addressed to NHS chief executives, headed up "Queen Elizabeth University Hospital", which begins:

> "Following my call with you on Tuesday 22 January about the ongoing incident at the Queen Elizabeth University Hospital…"

Do you see that?

A Yes.

Q A number of people have indicated that that might be what you have referred to as the "pigeon dropping" incident.

A It is.

Q And you see that there is a number of assurances that are sought. If we just look to the fourth bullet point, it says:

> "All critical ventilation systems should be inspected and maintained in line with 'Scottish Health Technical Memorandum 03-01: Ventilation for healthcare premises.'"

Do you see that?

A I do.

Q So, again, should the Inquiry understand that, at least by January 2019, there is emerging issues at the Queen Elizabeth University Hospital of such seriousness that the Scottish Government wanted to seek assurances from other health boards in relation to compliance issues? Thank you. We can put that document to one side for the moment.

I would like to just pick up the main chronology of decision-making. So that is the January/February Settlement Agreement, signed. This matter seems to come back onto your radar on 2 July 2019. Is that correct?

A Yes.

Q Just explain in your own words, what happens on 2 July 2019? What are you being told at that point?

A So, I was told on 2 July that there was a serious problem with the ventilation in the new hospital where the standards required in certain parts of the hospital, air changes of 10 per hour, and the tester had found that it was only 4.

Q And at this point in time, you tell us within the statement that, albeit this is early days and you are just being told, you already had very significant doubts as to whether the hospital could actually open a few days later on 9 July. Is that correct?

A That's correct.

Q Yes, and, again, just for the benefit of the Chair's notes, the issue of the Queen Elizabeth University Hospital, this is now quite significant in the forefront of your mind. If I can ask you to look within your first statement, at bundle 1, to page 173 and to paragraph 40. So approximately three lines up from the bottom. So over the page, onto page 173, we look to the three lines up from the bottom of paragraph 40. We see wording beginning, "I also did not want…" Do you see that?

A Yes.

Q So you say:

"I also did not want a repeat of the QEUH where you try to retrofit to fix something and that potentially raises other issues around infection control."

And then if we look on within-- still within your statement, to page 199, this time to paragraph 127, approximately four lines down you'll see a sentence beginning, "I was clear that…" Do you see that?

A Yes.

Q You say:

"I was clear that, as a lesson learned from the QEUH experience, I did not want major retrofitting going on once the hospital was occupied."

Do you see that?

A Yes.

Q Again, could you just perhaps explain-- We have now moved onto the summer of 2019 and you have concerns because there is retrofitting going on at the Queen Elizabeth University Hospital. What is happening at the other hospital in Glasgow at this point in time?

A So there are at least two major problems with retrofitting, possibly three. First of all, in order to do it you often have to decant patients from where they are to an alternative, and when you're talking about critical care you're talking about very sick patients – in this case, very sick children or young people – and you're moving them. So that's the first difficulty in terms of the quality of their experience, not necessarily the-- not at all, in fact, the quality of care they're receiving from their clinical teams, but the quality of their experience and what the clinical teams have available to them to provide that care.

Secondly, you are-- where you're talking about something like ventilation, then you are in effect pulling down in order to put back up. So you are producing dust, you're producing noise. Dust in particular carries a risk of airborne particles that may themselves be infectious or-- but if not, they will harm the quality of air in that hospital for any-- be it patients or staff, and thirdly, retrofitting takes time because of all the constrictions of trying to have a building site in a place that is occupied. You know, if we just think about even our own homes, where we continue to live there if there is major construction work going on, it is restricted in how it goes about its business, but so too are our lives. Now, you know, map that onto a hospital of very sick children and

young people. That is not a situation you want to have if you can possibly avoid it.

Q Okay. So, had you had the experience with the Queen Elizabeth University Hospital of trying to retrofit a hospital that has already opened, it is already treating patients, to try to bring that up to fully comply with published guidance? And you have told us that there are all these problems of trying to do that after the hospital is opened, and you wanted to avoid that for the Royal Hospital for Children & Young People and the Department for Clinical Neurosciences.

A Yes. That's absolutely correct, and also, I could not see how it would be possible to justify to those young patients or the patients at DCN or their families, far less the wider public, moving people into a new build that was not safe in terms at least of the ventilation. And of course, in addition, given how late we were being informed of this, I had questions about whether or not everything else that is important in a built environment was satisfactory and was meeting standards.

Q And I think you very clearly explained in your evidence earlier today that certainly to your

mind, you have the guidance. The guidance is equivalent of a bare minimum safety standard, so if you are not complying with the guidance, you are not providing a safe environment for patients, but had that thought process been reached? Or at this point in time, 2 July, was effectively the safety of the system as built, was that an unknown, or from your perspective, because it did not comply with the guidance, was it known that the hospital was not safe?

A As far as I was concerned, it was known that the hospital wasn't safe in that respect. What was not known was whether it was safe in other respects.

Q Thank you.

A And, of course, the provision of safe and effective healthcare is not solely about the built environment, but it is a critical element to that, as I think the experience at Queen Elizabeth tells us.

Q Thank you, and if I could ask you to look to bundle 7, please, volume 1 and to page 37. You see that this is an email from Alan Morrison. It is the email towards the end where he says:

> "Please find attached a short briefing regarding an emerging issue with the new

Edinburgh Children's Hospital."

And then, we see the briefing note over the page, onto page 38. You see in the background section, if we pick matters up in the second last paragraph, it says:

> "A derogation was therefore agreed to reduce the air change rate from 6 to 4 times per hour in 14 out of the 20 four-bedded rooms. A Settlement Agreement was signed to that effect in November 2018. Included in that Settlement Agreement was specific reference to the Scottish Health Technical Memorandum (SHTM) Health Facilities Scotland. It specifies a standard of 10 air changes per hour for critical care beds. It is not yet clear if the Contractor, Multiplex, has interpreted the derogation as 'overwriting' SHTM specifications.
>
> It should be noted that there is a zero rate of air change in critical care at the existing Royal Hospital for Sick Children. There are 19 critical care beds at RHSC. The new RHCYP has 24 critical care beds."

Do you see that?

A Yes.

Q So, in terms of this issue of safety, the hospital at Sciennes that did not have any mechanical ventilations, so it could not guarantee any particular air changes, and then you had the published guidance that said 10. You had this new hospital that had four. A number of individuals that have given evidence to the Inquiry have said that Sciennes was a safe hospital to treat children in, albeit it did not have any mechanical ventilation. Were you having those types of discussions with clinicians or experts, either at this point in time or subsequently?

A Yes, I was. Yes, I was, because it's not enough simply to think, "Well, the new hospital doesn't meet the standards, so we can't open it." You have to think about the consequences of that. There isn't a decision here that is risk-free. There is no option that is risk-free. So I'm looking at, "Well, if we don't open it, and at this point on 2 July, 3 July, 4th, we don't know how long that might be the case, what is the situation? What is the assessment of the situation in the existing Sick Kids and in DCN?"

And, of course, the reasonable advice that comes back is, well, neither of those two facilities are what we want, otherwise we wouldn't be building something new, but we know what the risks are there, and we know

how to mitigate and manage those, and we have the data and the information to support that. That's on the one hand, and on the other hand, we have a new build, not yet open, that in one critical area we know is not meeting the standard, which is a standard of best practice, and therefore it cannot be considered to be safe.

Q Okay. So, again, can you just perhaps help me? If Sciennes is safe, albeit it has no mechanical ventilation, no air changes per hour, why was the Royal Hospital for Children & Young People and the Department of Clinical and Neurosciences, which had four air changes per hour in critical care, why was that unsafe?

A Because it didn't meet the standard. I mean, Sciennes is a Victorian hospital that-- where it was not possible to insert mechanical ventilation without-- probably without decanting the whole hospital, but the effective mitigations that had been put in place and the quality of the clinical care all produced evidence that it was a safe environment. You've got a new build that has taken some time to build, has cost a great deal of money, and in one critical area does not meet the standard now required in this decade. Why would you move people into that from an environment which has proven itself, albeit without mechanical ventilation, but with high quality care, significant mitigation, and good infection prevention and control? Why would you move people from that into one that is not meeting the standards that are required now to assist effective and safe care?

And the alternative is that you move them in, and then you try and fix it, and we've already covered the risks that that carries. So I have a set of known risks, if you like, on the one hand, which is people stay where they are, patients stay where they are, and I have a set of unknown known risks on the other.

Q Thank you. Still within the briefing note, if we could look to bundle 7 volume 1, over the page onto page 40. You see the bold heading "Critical Care" and it says:

> "An interim solution has been put forward by Multiplex to increase current 4 air change rates."

So I will not read out all of option 1, but effectively there was one option that said, for certain rooms, they could be increased to 5.2 air changes. For some other rooms it could be increased to 7.1, but, again, from the

evidence you have given this morning, should I understand that from your perspective, none of those solutions would be acceptable because they are not meeting the standard in the guidance of 10 air changes per hour?

A That's correct.

Q At the bottom of that, the page on this briefing note, you see the heading "4. Risk Assessment". Do you see that?

A Mm-hmm.

Q And it says:

"Our Lead Infection Control doctor, Consultant Microbiologist Donald Inverarity advised that all air exchange rates are currently better than we have today, therefore will be in an improved position, but would wish external advice from HFS/HPS. He felt they were best people to advise of risk running with less than 10."

Do you see that?

A Yes.

Q Do you recall any risk assessment being done or any advice being provided by HFS or HPS as to the specific risk of 4 air changes per hour as opposed to 10 air changes per hour?

A Not directly to me, but of course my lead advisor in terms of infection prevention and control in this area-- well, two lead advisors, were the chief medical officer and the chief nursing officer, and they were clear that 10 was the required number of air changes.

Q Okay, so the advice that you were getting from the chief medical officer and the chief nursing officer is, the guidance says 10, so this new-build hospital has to have 10 air changes per hour.

A Yes.

Q So, from that perspective, one might think at this point in time, you are a few days away from the hospital opening, you have got to make a decision. Perhaps understandable that no risk assessment is done at that point, but should the Inquiry understand, really, from your perspective, there would be no point in doing a risk assessment thereafter if the chief medical officer and the chief nursing officer are telling you new-build hospitals have to have 10 air changes per hour?

A The standard is telling me that. The guidance drawn up by experts is telling me that, and my chief medical officer and my chief nursing officer are firmly of the view that the standard requires to be met.

Now, as I've said, I'm not a clinician, I'm not an infection

prevention and control expert, but I cannot see the point of dancing on the head of a pin about whether or not it is 7.1 or 6.2, when 10 is what is required. 10 is what is required, so we will have 10, but also as I've said earlier, part of what is in my mind is, can I be confident that in terms of water, drainage, fire, any other critical matter to a built environment, that this hospital is currently meeting all the required standards except in ventilation? And of course, as we see subsequently, it was not.

Q Thank you. If I could ask you to move on, please. Still within bundle 7, volume 1, and look to page 66. So bundle 7, volume 1, page 66. Presumably, as you tell us in the statement, in this period, 2-3 July, in addition to the emails that we will look at, there is a flurry of meetings and discussions that are taking place, presumably some involving you, some involving your officials and NHS Lothian. Can you just explain in your own words, what was your understanding of NHS Lothian's position at this point in time? Did they want to simply open the hospital, or did they have concerns about patient safety if the hospital was just opened?

A Oh no, they had-- they were taking it very seriously indeed

and had concerns about patient safety. I think they were of the view that the hospital could not open on the 9th, and it was whether or not-- what were the other options at that point?

Q Thank you. Because if we look within bundle 7, volume 1, page 66, this is an email from the chief executive of NHS Lothian to the Scottish Government. If we just pick matters up in the second paragraph beginning, "It is worth reiterating…" Do you see that? It says:

> "It is worth reiterating that our guiding principle in dealing with this problem and all previous problems and delays associated with this building project has been to prioritise patient safety and only to commission services in the new building when we believed it was fully fit for purpose…"

Do you see that?

A Yes.

Q So, effectively, at this point in time, there seems to be a commonality in approach between both yourself and Scottish Government and NHS Lothian that the driving factor in all of this decision-making must be patient safety?

A Yes, absolutely.

Q And if we look onto page

68, we see that there is a range of options that are set forth, and it is really the fourth option there, beginning, "Re-phase." Do you see that?

A Yes.

Q So, the email says:

"Re-phase the timings of the move into the building to allow a phased occupation over the next few weeks and months:

This option was supported as the best option. It would allow the permanent optimum solution for the critical care ventilation issue to be implemented in an empty ward without clinical risk and with limited disruption to the other users of the building; it prevents the need for double moves including a decant; it would allow DCN services to move in as planned; and it would allow ambulatory paediatric services including outpatients, therapies, programmed investigations and day surgery to move in over the summer."

Do you see that?

A Yes.

Q So, perhaps a disagreement as to how long the pause is going to have to be, but it seems that there is a consensus view emerging over 3 July that the services simply could not move on the 9th as planned.

A Yeah, so there was agreement. I think, yes, there was consensus that the move could not happen on the 9th. As you say rightly, their supported option was number 4, which was about rephasing the timing, but that was, I assume, predicated on a view that the issue to be resolved was around ventilation and critical care.

Q So----

A As I've already explained, I had additional concerns.

Q Mm-hmm, and at this point in time, did you still have confidence in the leadership team at NHS Lothian?

A Yes.

Q Okay. If I could ask you to look at your statement, so it is the main statement, page 177, paragraph 55, and if we pick that up, three lines from the end of that paragraph beginning, "I could not have…" Do you see that?

A Mm-hmm.

Q You say:

"I could not have confidence in the governance performance of NHSL and consequently that all other required standards in the

build had been met."

Do you see that? It is just-- It is obviously a failure on my part. Did you or did you not have confidence in NHS Lothian at this point in time?

A So, I had confidence in their ability to work with us to resolve this problem. That's not the same as saying, "I had concerns around the standards of governance," and concerns about, "Why was this only being picked up now?" I think that's entirely reasonable. Of course, on 2, 3 July, there was a lot that we did not know about, "How had this problem arisen and why had it gone unnoticed, and why were we finding out at the last minute?" And then linked to that, my concern, to be sure that every other aspect of the build was meeting the required standards.

Q Okay, but, again, just if we think through the meetings that are taking place, the discussions that are taking place, at this point in time the senior management team at NHS Lothian, they have identified the problem. They have escalated it to Scottish Government. They have highlighted potential resolutions, and they are indicating that they think there should be a pause to make sure there's a resolution. Is that correct?

A Yes.

Q If I can ask you to look to bundle 7, please, volume 1, at page 48, so this is an email on 3 July from Alan Morrison of the Scottish Government. Perhaps just to pick matters up towards the bottom of the page, if we could zoom in on the section that says, "There is still a lot of unknown factors including…" Do you see that?

A Yes.

Q So, Mr Morrison says:

"There is still a lot of unknown factors including:

The safety implications of running the facility with 4 air changes rather than 10."

Do you see that?

A Yes.

Q From your perspective though, that would not really be an unknown because from your perspective, if there's not 10, it's not going to be safe because it doesn't comply with the guidance. Is that right?

A That's right.

Q There is a range of other unknown factors, including the "Risks of modifying the building whilst occupied", which I think we've already covered:

"The safety of the environment in which the patients

are currently occupied, i.e. is the new facility with 4 air changes an hour still safer than the current site?

[Then the] Viability of proposed permanent solution has not been sufficiently tested or challenged."

We've spoken a little bit about the hospital at Sciennes, the children's hospital. The Inquiry has heard evidence it's a Victorian hospital, no mechanical ventilation, issues with the infrastructure, but fundamentally no issues around about provision of safe care to patients. What about the Department for Clinical Neurosciences? What was the position with the DCN at this point in time?

A So, DCN was arguably the most pressing of the two facilities to move to a new build. That was partly around-- They had an issue in terms of their water in one particular area, the facilities. In common with Sciennes, the building was in some disrepair, but the principal issue that they were addressing and working to mitigate was around water in a particular part of their facility.

Q Thank you.

A That, from memory, had reduced the capacity that they had, i.e. the number of patients that they could treat.

Q Okay, so with the hospital at Sciennes, a pause is not really going to have any particular significant impact, albeit patients are being treated in a substandard physical environment, but with the DCN there is actually issues because of problems with the water system and a reduction in capacity for the treatment that can be provided to patients. Is that fair?

A Mm-hmm. That's correct.

Q Thank you. In terms of the chronology, you then make the formal decision on 4 July that the hospital is not going to open. Is that correct?

A Yes.

Q Again, I think we have covered the majority of the reasons, but could you just explain in your own words why you make that decision on 4 July that the hospital was not going to open?

A Because I did not believe that the new hospital-- In fact, I knew that in one important area it was not meeting the required standard, and I did not have the assurance I needed to be confident that elsewhere in the building the required standards in

terms of, as I've said, water, drainage, other matters were also being met, and I needed that assurance.

Q Okay, thank you. Now, the Inquiry has heard evidence from Mr Davison, the chief executive of NHS Lothian, and his position is that after you made the decision on the 4th that the hospital is not going to open, no one from Scottish Government lifts the phone and lets him know in advance about that decision. Were you aware of that?

A I was aware that that is what he said.

Q Okay.

A I think it would be fair to say that colleagues in Scottish Government might query that assertion, and I think Mr Connaghan indicated to the Inquiry that there was a conversation that he had the evening before the 4th, in the evening of the 3rd, which certainly would give a very clear indication to Mr Davison that the move was not likely to go ahead on the 9th. Indeed, that was in fact their own preferred option.

Q Mm-hmm, but if Mr Davison's right and he was not given the courtesy of a phone call to say the decision has been taken that the hospital is not going to open, why would that be done?

A Well, it would not be for me to make that phone call, so I think it's a question best put to other witnesses.

Q Mm-hmm. As Cabinet Secretary though, would you not expect your officials, as a common courtesy, to let the chief executive of NHS Lothian know that the formal decision had been taken and that the hospital was not going to open?

A In this period, to be frank, I had more important things to worry about. I had confidence in my senior officials. I knew that they were in fairly regular contact and discussion with the chief executive and other senior members of the NHS Lothian team, and it did not occur to me to question how they were handling those conversations.

Q Mm-hmm. Perhaps just thinking back to when you sat on the board of the National Waiting Times Centre, could you see from the Health Board perspective, if a decision was announced that the hospital was not going to open and the Health Board does not have advanced notice of that, that that could create operational difficulties for them?

A No. I think when I was chair of Golden Jubilee Foundation, had we been in this situation and had

the conversations with the DG in Health and with the chief operating officer for NHS Scotland, and indeed had put forward as our preferred option from my hospital, my board, that we should pause the move, then it would not be a big surprise to me when that was announced.

Q One of the points that Mr Davison made was that he was told explicitly that Scottish Government would require to approve all communications that went out. So at the point in time that the announcement is made, announced to the public that the hospital is not going to open, he was in a position whereby patients, families, staff members were all asking the managers at NHS Lothian what was happening, and they were not allowed to communicate directly because any communications had to be approved by the Scottish Government. Were you aware of that?

A Yes, I was aware of it because it was my decision. The reason for that decision was because I wanted all communications to be aligned, because it was really important that what we said publicly, the support that we put in place, the helpline that was put in place, what the Board was doing in terms of rebooking patients for procedures, including

outpatient appointments, ensuring that there were staff at the new build to assist anyone who went there instead of where they needed to go now, that all of that was streamlined, smooth and in place.

The reason for that is because we are telling the public of Lothian, Edinburgh and the Lothians but wider, that this new hospital is not going to open when they have been led to expect it would open because, at least in one area, it is not considered safe. That is at best disconcerting for the wider public, but absolutely upsetting, worrying for patients and staff and their relatives, and they need an assurance that work is underway to get to the bottom of the matter, resolve the issues and put in place the necessary help and support for them. So that's why I wanted the communications aligned, but, also, I had made the decision that the new hospital would not open. It felt entirely right to me that I should be accountable to that public for that decision, and therefore I should front those communications.

Q So, you----

A Now, subsequently there was of course absolutely nothing to stop Mr Davison communicating with his staff. I communicated directly with his staff, as well as with the unions and

others.

Q But I thought Mr Davison and NHS Lothian, they were not allowed to have any communications that weren't pre-approved by the Scottish Government.

A That's right.

Q So, how could he have simply had open, frank discussions with his staff if he had to get pre-approval from the Scottish Government?

A So, there's a presumption in your question that approval from the Scottish Government precludes open, frank communication, and that's a presumption I would dispute.

Q Okay, so whenever Mr Davison was told that he could not make any communications without Scottish Government approval, he could still simply have had discussions with his staff members, patients, families without the Scottish Government approval. I am struggling to follow. It is no doubt----

A So, communication is written communication. I don't think it's difficult to follow. He would obviously be briefing his senior team on the decision and the work that he was advised Scottish Government was commissioning. There was a lot of communication and interchange between the Scottish Government communications team and NHS Lothian's communications team to make sure that everything was aligned and that steps were being put in place. So there's written communication, there's public communication, and then there's internal communication with your staff groups, with your unions, with your senior team, which, of course, NHS Lothian would have undertaken.

Q Okay, and were you content with the communication strategy that was put in place?

A Yes.

Q Thank you. Lord Brodie, I am conscious that is just after half eleven. Now might be an appropriate time to take a break.

THE CHAIR: Ms Freeman, as I indicated, we usually take a coffee break about now. Could I ask you to be back by ten to twelve?

THE WITNESS: Thank you.

(Short break)

THE CHAIR: Mr MacGregor.

MR MACGREGOR: Thank you, my Lord. Ms Freeman, just before the break, we were discussing the communication strategy and you had

explained why Scottish Government and yourself as Cabinet Secretary had taken control of communications. I will not go through your statement but, for the benefit of the Chair's notes, in your first statement, you cover that at page 182 at paragraph 75, and then in your second statement, you cover that on page 17 at paragraph 18 but, essentially, you wanted to ensure that all communications were what you describe as "consistent, transparent, open and straightforward." Is that correct?

A That's correct, and, in addition, that I led them as the person who'd made a decision and as the elected person accountable to Parliament and the people of Scotland.

Q And you were content, you said before the break, with the communication strategy?

A Yes.

Q I would just like to draw to your attention some observations that have been made by patients and family groups in relation to their view of the communication strategy, which is rather different. So, Lesley King, who was the mother of a child being treated at the hospital in Sciennes, she provided a witness statement to the Inquiry. This is her observation at paragraph 79 of her statement on the communications. She says:

> "As parents, we did not have any formal communication from the hospital or the Health Board about why the move to the new hospital had been delayed in July 2019. I only heard about the reasons for the delay from what I read in the press… The staff in the hospital were very open and frank with us and told us what they knew, which was not a lot."

Then she goes on at paragraph 80 to say:

> "There was never any communication from the Chief Executive of the hospital, or anyone in management to us acknowledging the delay or the effects it had on the patients and families. Yes, the Chief Executive had been on the ward at the time of the delay but we were focused on … treatment and too upset to speak with the Chief Exec at that point. It was a similar situation when the Health Secretary visited the ward."

Viewed in that context, does that-- the experiences of patients and families, do you still think that the communications with patients and families were adequate and appropriate?

A Well, just on the point about staff, I personally wrote to staff on at least two occasions, and one of those would have been around 4 July, explaining why I'd taken the decision, and then later, in 18 or 19 July, updating them on where we were at that point, particularly for those staff that I wasn't able to meet when I visited both DCN and Sciennes.

In terms of parents, I completely appreciate what your witness has said and I'm sorry that they feel that they were ignored by the Board, but also I would take it as ignored also by me, and that is remiss because I think it is really important that patients and families know what is happening and why it's happening, including what we don't know at any particular time but what we're doing about it.

Q So, if we just think, perhaps, to recommendations the Chair may want to make, you have explained the difficulties, it is clearly a busy period, 2nd/3rd/4th when the decision is being made. Given the experiences of patients and families, their perspective of the communication strategy, how do you think that could be improved if a situation like this ever arose again?

A I think very straightforwardly. I think that it would be entirely possible, given that it was possible and the Health Board did an exceptional job in contacting patients to re-book them, either for procedures or for outpatient appointments, over a very short period of time. Therefore, there are-- that information is available. It would be straightforward to send a letter-- More than once actually. You could send an initial letter that says, "We're really sorry, but for safety reasons, we can't open the hospital when we planned and work is underway," what we know and what we don't know, and then you could send a further letter at a later stage keeping people up to date. So I think that would be an important thing to do, should we ever be in that situation again.

Q Thank you. If I could ask you to look to a briefing note, please, bundle 13, volume 4 at page 469. So bundle 13, volume 4, page 469. So it is a briefing note just confirming some communications that took place. So the first bullet point says:

> "You wrote to staff on 18 July and visited the existing Sick Kids and DCN sites the same day to provide an update and to answer questions that staff may have in response to the decision to delay moving the hospital to

the new site."

I will come on to ask you about that site visit in a moment. It is the next bullet point:

"Alex Joyce (Unison), Employee Director and Joint Staff Side Chair of NHS Lothian wrote to you on 23 July 2019 requesting a meeting to discuss concerns that Staff Side had been excluded from any communications regarding the decision not to open the Sick Kids Hospital. These concerns were also raised within the press, including in the Scotsman."

Do you see that?

A Yes.

Q Do you recollect, what were Alex Joyce's concerns that were raised with you?

A So, from memory, the concerns were that the Staff Side unions in NHS Lothian had not been advised during the period where discussions were underway, and at the time or immediately thereafter, about the decision not to go ahead with the opening of the hospital on 9 July. That's my memory of that, but there may have been other concerns that they had that I'm not recalling.

Q Do you think the unions should have been more involved in the decision-making process than they were?

A Not necessarily. The unions certainly were involved subsequently because a number of the matters that we asked NSS to look at came directly from the Staff Side of NHS Lothian and specifically from Unison but, in the decision-making itself, I don't believe so, but I do take the point, if my recollection is correct, that Mr Joyce is making about informing them sooner than they were informed and, of course, as the note then goes on to explain, I met the unions, I met Staff Side on 13 August and we continued that dialogue.

Q Again, in fairness, the minute does continue to say that you met on the 13th and you confirmed your position in writing to Alex Joyce on 19 August, and then the next bullet point says:

"Upon publication of the reports, you wrote again to Alex Joyce and to all affected staff in NHS Lothian (11 September)…"

So, from the point Mr Joyce-- or the point Alex Joyce raises matters with you, there does seem to be engagement but, again, if we are just thinking about how these things could perhaps be better done in the future, do you think that there could be closer

and better communication with unions and staff than took place in the early period in July?

A So, I think there was direct communication from me to staff in July, in the early period and then mid-July, but that should not be at the expense of no direct communication with Staff Side representatives which, of course, encompasses all the unions involved in healthcare.

Q Thank you. If I could ask you to look to bundle 7, please, volume 1, page 86, which is a record of an interview that you did on BBC Radio Scotland on 5 July 2019. If we could perhaps pick matters up around a third of the way down, there is an entry on the left, "JF", and it is attributed to say, "I did and I did that entirely for patient safety…" Do you see that?

A Yes.

Q So, you say:

"I did and I did that entirely for patient safety, because there's two reasons: one, of course, is critical care needs to be safe, it needs to meet national standards; you can't have an emergency department if you don't have critical care, but also because this was picked up so late I want to be assured that all other safety checks in the rest of the hospital are also conducted again independently and that they meet national standards too."

Do you see that?

A Yes.

Q So that was the messaging that you were providing on 5 July, explaining to the public why you had taken the decision that you had.

A Yes.

Q And if we look down, approximately two-thirds of the way down the page, you see there is an entry, "JF", that says, "Yes, and so one of the things that I need to find out is why NHS Lothian is so confident…" Do you see that?

A Mm-hmm.

Q It says:

"Yes, and so one of the things that I need to find out is why NHS Lothian is so confident that the hospital was meeting all those standards when self-evidently in critical care it certainly wasn't."

Do you see that?

A Yes.

Q So, did you get to the bottom of that issue about, NHS Lothian had been very confident but the standards were not being met?

Did you get to the bottom of how that had taken place?

A Well, yes, because it partly relates to what we were discussing earlier and a matter we've not yet come to, and that's twofold. First of all, NHS Lothian were receiving assurances from their advisors in terms of how the project was proceeding and that they had given the assurance in response to Paul Gray's letter in January, which I think came from the Strategic Facilities Group's concerns, arising primarily about water in Queen Elizabeth but touching on other areas. So they had given those assurances in response to Paul Gray's letter and they were, I presume, relying on receiving those assurances from their advisors in terms of standards, but what wasn't happening, as we've touched on earlier, is scrutiny within governance structures.

And I think the second difficulty which I became aware of is that when assurance is given that a particular aspect of the built environment is meeting standards, it is primarily a paper-based exercise and so nobody is literally going and switching on the lights to make sure the lights work. They have all the paperwork to say the lights work and they tick and say the lights work, and so that-- and that was

standard practice. That wasn't something where NHS Lothian had got it wrong or specific to them. It was standard practice and that, it occurred to me, was not, in the final result, the kind of assurance that we needed in critical areas of a built environment.

Q And we will perhaps come on to discuss this slightly more with NHS Scotland Assure, but you are very clear in your statement in terms of saying, in your view, what the centre of excellence needs to be is effectively a clerk of works: someone walking around with a clipboard. You describe it as pushing buttons, being the type of person that someone would not want being on site, asking all the difficult questions. That is your vision of what the centre of excellence should be. Is that right?

A That's part of what it-- I wanted it to be, where you actually-- when you say you've tested ventilation, water, drainage, fire dampeners, you actually have gone and tested them. Now, when you do that, at what point in a build you do that, of course, is for those with the relevant expertise to decide. But, again, if you think about a more personal situation with your own home, if you buy a new home or if you have work done in your home, you actually

do go and press those buttons and turn on those switches to check that the work that's said to have been done, and you're paying to have been done, has actually been done. You don't simply take a bunch of paperwork from the builder and it's all ticked and you're happy. So, it seemed to me that we needed to find a way to reinsert that actual physical testing of critical aspects and, as you say, I characterise that as a clerk of works.

Q The Inquiry has obtained statements from individuals that work at NHS Scotland Assure and their position is, whatever the new body is, it is not fulfilling that clerk of works role, it is not doing any inspecting, it is not doing any testing. If that is right, if the clerk of works model that you had envisaged has not taken place, is that a missed opportunity in your view?

A It's only a missed opportunity if nobody is doing it, so it may be the case because, of course, what has happened with NHS Assure I have not been part of and ought not to comment because I've not been there to understand how it has developed and been established. But what I would say is, if that is not what they're doing, I would think it is their job to make sure that somebody is doing that.

Q So, regardless of who physically does it, if you are having a centre of excellence there should be someone that has done those physical checks, in your view?

A Yes.

Q Thank you. Just perhaps to finish matters off on the radio interview, if I could ask you to look to bundle 7, volume 1, page 87. So there is a comment made during the course of the interview that it is the same contractors that have worked on the Queen Elizabeth University Hospital and the Royal Hospital for Children & Young People, and you will see the question posed at the top. It says:

> "Well, was the mistake to have the same firm build both hospitals the QEU and the Sick Kids in Edinburgh?"

And your response is:

> "Well, there is no indication at this point that any fault lies with the contractors themselves."

Do you see that?

A Yes.

Q So, did you subsequently consider that there was any fault that lay at the door of the contractors themselves?

A I don't think I formed a view on that, primarily because I had

no engagement with the contractors. I did not put questions to them and consequently they did not have the opportunity of answering those questions to me. So we certainly had no indication at that point and I was not prepared to say anything other, but subsequently there would be no basis for me saying that there was or was not any fault on their part. What I was focused on was NHS Lothian's responsibility as a statutory body and, arising from that, as we've touched on, whether or not the role of Scottish Government in these major builds is as fulsome as it might need to be.

Q Thank you. The reason I raise it is the Inquiry has heard evidence that with the NPD model it was meant to be a move towards more of a partnership approach in terms of these new-build hospitals. So, you had a project company that was set up, but it had a public interest director that sat on the board. It was to try to foster this idea that the parties were working in partnership. Do you find it surprising against that backdrop that the contractors built a hospital where the air changes were less than 50 per cent of what is set out in the published guidance without raising that issue specifically with NHS Lothian?

A I genuinely don't think I'm

qualified to comment on that because I'm-- as I've said, I've not had conversations with the contractors, so I've not had the benefit of their explanation about the approach that they took and why they took it, nor have they had the benefit of putting that to me. So I don't believe I'm qualified or that it would be fair for me to comment in response to that.

Q Thank you. If we put the radio interview to one side, we have heard already that you attended a site visit at the Children's Hospital on 18 July. The Inquiry has heard evidence of the experiences of patients and families when they found out the new hospital was not opening. The evidence indicates that patients and families were flattened, they were very, very scared about what was going to happen to their children and they were very, very upset. What was your experience of visiting the hospital on 18 July and meeting patients, families and staff members?

A So, it was that. I also visited DCN on the same day and I had with me Malcolm Wright as the director general for health and Dr Catherine Calderwood as the CMO. And I very deliberately had it as a small visit as opposed to sometimes what you get is the whole ministerial

entourage, because I wanted as much of the time that we were there as possible to be spent listening to what staff primarily – because it was primarily staff I met – were saying to me. So I wanted to be able to explain directly to them why I'd taken the decision I'd taken, what we had put in train to try to get to the bottom of this, what we had put in train to see what else might need to be done in the hospital, the fact that I did not know at that point how long any of this might take, all the things that I didn't know and the commitment to keep them up to date and informed, and, of course, as I've said, parallel to that I wrote to all staff.

What I heard from them was very similar. People were upset. They were shocked. They were frustrated because they'd waited a long time. They were surrounded by packing cases. They had made personal arrangements in terms of how they would get to the new hospital compared to where they were currently based. Some had taken on roles specifically because it was going to be in the new facility.

But at the same time, they-- I had no one say to me they thought it was the wrong decision. They all went very quickly to the point of, "If it's not safe, we shouldn't go," but I also wanted to follow on from that in the discussion with them and be there for as long as we needed to be there. "So, if you have to stay here and we don't know how long that might be, what does this hospital need then? What do you need?" And there were a number of suggestions about basic maintenance, the kind of things that had been allowed, reasonably, to run down because there was an expectation of a move, but some major points: A&E, Sciennes being the main example where the clinicians very clearly pointed out the removal of a pillar would-- and the reallocation of space would allow better patient observation and better patient flow, and therefore make their jobs significantly easier.

And, similarly, there was issues raised about support and accommodation for families, a situation I knew of personally from my own family about what was available there. Not every patient – a young person or child requiring critical care attention – is from the Edinburgh area. Often they have come from quite far afield, so there's a need for improved accommodation and support for families, and then when we went to DCN, again, a similar exercise and a similar response from staff there.

Q Thank you, and if I can ask you to look to bundle 7, please, volume 2, page 113, we see a briefing that was provided to the First Minister. If I could ask you to look to paragraph 7, please. The briefing notes:

> "NHS Lothian have also been asked to monitor any complaints received about the situation, but no complaints have been reported."

Do you see that?

A Yes.

Q So, anger, frustration, disappointment on the part of patients, families and staff members, but fundamentally people are not actually making formal complaints about what has happened. Is that correct?

A Yes. There were no formal complaints, as I understand it, to Scottish Government and NHS Lothian advised us that they had at that point not received any either. Of course, the unions were raising issues and, as I said, I can't recall exactly-- it may have been on fire, the fire question, but the unions were asking for NSS to look at other areas inside the new build. It was on drainage, in fact.

Q Thank you, and you have outlined the difficulties associated with the hospitals, the suboptimal environment at Sciennes, the issues arising from the water quality in particular at the DCN, but in your position as Cabinet Secretary, were you aware of any information suggesting that there were any adverse clinical outcomes for any patient associated with the hospital not opening?

A No, I was not aware of that, and I know that the CMO was in conversation with the clinical teams in both sites, both before and after that visit, and had she been aware of any she would have raised those with me.

Q Thank you, and just on the briefing for the First Minister, if we look to paragraph 8, the site visit, the briefing states:

> "On Thursday, I visited both the existing Children's Hospital and the DCN at the Western General Hospital. Both visits were extremely helpful as they allowed me to see first-hand the level of disappointment and inconvenience for staff that the delay has caused and also the impact and disruption on patients."

Do you see that?

A Yes.

Q So, escalation. So the First Minister is aware of these very

significant difficulties that are occurring as a result of the problems with the project?

A Yes.

Q Just to look to the scale of the issues that were facing patients and families, if I could ask you to look to bundle 7, please, volume 1 at page 303. So bundle 7, volume 1, page 303. If we just look to paragraph 2, under the bold heading, "NHS Lothian Patient Contact", it says:

> "As you are aware NHS Lothian have been contacting patients by telephone for those who have appointments in July and issuing letters to patients who have scheduled appointments from August. We met NHS Lothian today and requested regular information on the patient contact position and these reports will now be provided from Thursday 11th July. The total number of outpatient appointments for the month of July across the affected areas are: paediatrics,1,586 and the DCN is 669."

Do you see that?

A Yes.

Q A total of 2255, and then it continues at paragraph 3:

> "NHS Lothian have made contact with over 800 paediatric patients and 101 of the DCN patients."

Do you see that?

A Yes.

Q So, for this one month, presumably there are impacts for further months, but you are talking about just under a thousand patients that are going to be impacted by this issue?

A Yes.

Q At this point in time, had you reached any preliminary views as to where the fault lay in terms of the problems with the hospital and the hospital not opening?

A So, this is round about the middle of----

Q Round about the time of the site visit, 18 July.

A 18 July. No definitive view. No.

Q Okay. If I could ask you to have before you, please, Mr Davison's statement. So that's in bundle 2 of the witness statements and if we could look to page 227 and paragraph 128, and if I could ask you to look at approximately four lines down, you will see there's a sentence beginning, "So the meeting didn't really go well." Do you see that?

A Yes.

Q So, Mr Davison says:

"So the meeting thing didn't really go well and then she [that's referring to you, Ms Freeman] expressed her view that it was the board's failure, and in particular a failure of governance."

Do you recall any such discussion taking place?

A So, could you remind me what meeting we're talking about?

Q So, I think at this point in time it is approximately around about this time. So it is around about the time where the decision has been taken that the hospital is not going to open, and then there is a series of meetings. It is not clear if this is happening at the site visit on the 18th, or a subsequent site visit, but it is a meeting that you had whereby there were certain individuals present, including Mr Davison.

A Yes. It may be the meeting I had immediately before I met the staff and others at Sciennes and then DCN, and it was with Mr Davison and the chair of the Board, Brian Houston, so it may have well been that meeting.

Q And does that accurately reflect your views in relation to where the fault lay?

A Not really. I don't believe I was dismissive either. I simply wasn't interested in long explanations about funding mechanisms and complications and complexities around who was responsible for what. What I was interested in was whether or not the chief executive and chair of the Board understood that, given their statutory responsibility, they were-- notwithstanding who else may have an involvement here, they were responsible for the situation we were now in, and that that had to be, in some part, a failure of governance. I don't believe I said it was the Board's failure, but I would have made a point about failure in governance.

Q Okay, thank you. Because at this stage, I would like to just move on and deal with the third issue, some of the problems with the project, and you outlined at the start that, really, you thought that the germ of the problem was human error right back at the start, before you were Cabinet Secretary, in relation to issues arising from the Environmental Matrix, and the fact that is not picked up at subsequent stages. Is that correct?

A Yes.

Q You will be aware----

A Sorry, I actually think the germ of the problem is the fact that it's

not picked up at various stages, because everyone can make a mistake. So the mistake being made potentially triggers where we end up, but only because at no point is it picked up.

Q Because Grant Thornton in their report commissioned by NHS Lothian, they refer to the matter as collective failure. Have you seen that report and are you familiar with that term?

A Yes, I have.

Q Was that your view that this is just a collective failure over the whole project?

A So, in part, I think would be my view. I don't think it is fair to pinpoint the blame, if you like, on any one individual. I think it is a failure of governance, and that means that either the right people weren't in the room when these matters were-- when governance was being practiced, or the right questions were not being asked or pursued, because I know from my experience as chair of a board as well as member of the board that you can ask the right question, but if you just then sit back and accept whatever answer you're given, that's not really governance either. So, in that sense, I think there are a series of failures, but they are for me primarily

around governance.

Q Okay, and if we are talking about a failure in governance, a collective failure, does that include the Scottish Government as well?

A No. I don't believe it does, because the Scottish Government delivered the role that it had always delivered in these matters, and of course, we have other instances of major builds around the same time, which are delivered by and large on time and on budget and without these issues arising, with Scottish Government playing exactly the same role in regard to them as they did here. That of course is notwithstanding my earlier comment that I do think the role of Scottish Government in relation to major healthcare builds going forward is worthy of examination.

Q And should I take from that, that you think the whole model at the minute may actually be wrong, and that is part of the problem?

A I'm not saying it's wrong. I'm saying that it is worthy of examination and part of the reason why I say that is, from the point of view of the public of Scotland, they really don't care who's got what statutory responsibility for what. What they care about is that public projects are well-

designed, well-managed, well-delivered and appear preferably on time, and as close to budget as possible, and the only place they can look to for accountability for that is Scottish Government and Scottish ministers, regardless of who that is.

So, given that is rightly where the public looks and rightly then the responsibility of Scottish Government and Scottish ministers, it is self-evident to me that therefore if you're going to be accountable for something, you need to have a greater role in it. But the reason I say "worthy of consideration" is because there is a legal framework in place that gives boards a legally defined statutory responsibility, and so you can't sweep that aside. You need to think through carefully, how do you get a better balance between Scottish Government, central government and health boards?

Q Okay, thank you. In addition to the Grant Thornton report, you will be aware that KPMG were commissioned by the Scottish Government to also produce a report and they describe matters as being a human error. They list a range of potential missed opportunities. Is that correct?

A Yes.

Q If I could ask you to look to a briefing that was prepared on the KPMG report. If we could look to bundle 8, page 91, please. This is a briefing prepared on the KPMG draft report. You see that there is a summary of the findings, paragraph 6, 3 lines up from the bottom. It says:

> "This appears to have stemmed from a document produced by NHS Lothian at the tender stage in 2012 which was inconsistent with SHTM 03-01 and which was referred to throughout the project."

And if we could look on, please, to page 93, you see at the top it records that the cost of the KPMG report was £300,000 and then in the summary section at paragraph 22, it says:

> "The main issue contained in the report is that a mistake included in the tender documentation was not picked up at any stage over the next 7 years, despite the fact that there was appropriate professional and technical involvement in the project, and that the governance arrangements operated as planned. The other issue of focus is that because the report provides a comprehensive

summary of each issue that this project has had to deal with, it brings attention to the unusually high number of problems with this project has experienced, and we may be asked why we did not intervene earlier."

Do you see that?

A Yes.

Q So, why did the Scottish Government not intervene earlier?

A Well, it's not clear to me from that report that the unusually high number of problems were all brought to the attention of Scottish Government, so I can't comment on why government did not intervene earlier or if government should have intervened earlier.

Q Okay, and then, if we look on to paragraph 23, it says:

"In addition to the obvious question as to why the ventilation problem was not identified by the board or any of its technical advisors, criticism of the project are likely to include questions about…"

And then there is a series of questions. It says:

"Why the contract was signed in February 2015, before the design was complete."

Do you see that?

A Yes.

Q Did you ever investigate or get to the bottom of, why is this contract signed in February 2015 before the design was complete?

A No, I didn't.

Q Okay the next question is, why was the practical completion certificate signed in February 2019 while there remained a large number of issues that needed to be resolved? Do you see that?

A Yes.

Q Do you know, why did that take place?

A I don't know. I can't comment on that. I did not know that there remained a large number of issues that needed to be resolved.

Q Okay. It then continues, "Why are we paying a monthly charge for a hospital we cannot use?" Do you see that? That is an issue I think the public would want to know. £1.4 million every month is being paid for a hospital that cannot be occupied. Why was that the case?

A It was the case because NHS Lothian accepted the handover, and as soon as they did, they were liable to pay that monthly charge. So they accepted the building, in effect, and were then liable by contract to pay that monthly charge. I found it galling

too, but it was NHS Lothian's decision, and it was part of the contract.

Q But it is the Scottish Government that provides the money.

A Yes.

Q So, is the key failing here not the fact that there is just assumptions made that everything is okay on the part of the Scottish Government at the point of Settlement Agreement 1?

A No. I don't accept that. The key failing is that where everything is not okay, NHS Lothian are either not aware or not raising it with Scottish Government.

Q Okay. And then, the final issue says:

> "How can we have technical guidance on ventilation systems which lacks clarity and is open to interpretation?"

Do you see that?

A Yes.

Q Was that an issue of concern to you?

A No, it was never raised with me that our technical guidance on ventilation systems lacked clarity. I don't know if that refers to a debate that I do know happens and I think has been rehearsed with this Inquiry, about whether it should be 10 or whether it should be another number, whether it is guidance or mandatory, or-- and etc., but my position, as I've said, was clear. We have guidance drawn by experts to represent best practice and it says 10.

Q One of the issues that the Inquiry has heard evidence about is the fact that there did seem to be different interpretations of what the guidance required, certainly in 2014. There is new guidance in 2022, but you effectively had two schools of thought. You had IOM Limited who do the testing on the one hand. They say all critical care rooms need positive pressure and 10 air changes per hour. You then had the design team, TÜV SÜD, who even whenever this issue was raised and even in their evidence to this Inquiry still say the 2014 guidance properly understood did not need 10 air changes per hour and positive pressure in all rooms in critical care. It simply had to be in isolation rooms. At the relevant time when you were making these decisions on the project, were you aware that the guidance was being interpreted in different ways by different engineers?

A Not in those early days in July.

Q Mm-hmm.

A Subsequently, I was aware that there was difference of

interpretation, but my clinical advisors were very clear to me that it required 10 changes per hour in critical care.

Q Okay, so the advice that you received later on in the project, was that effectively that, properly understood, there is only one way of reading the guidance, and the views of TÜV SÜD were an outlier, or were they saying, "This is my interpretation, but I can see that there is an alternative interpretation of the guidance"?

A Well, I think I'm not aware-- I'm not recalling that it was ever put to me like that, but I think-- I imagine that part of the reason why the guidance has been updated is an attempt to address concerns that may exist around clarity or it being open to different interpretations.

Q Is this back to what you tell us at page 195, paragraph 116 of your statement that the standards were there for a reason? So from your point of view, if you have the standards, you should be complying fully with those standards?

A Absolutely.

Q Do you think any of the difficulties associated with the project were related to it being revenue funded through an NPD model, as opposed to being a capital and build project?

A I don't believe I'm particularly qualified to comment on that. If I go back to my point about governance and the practice of governance, that applies regardless of what funding mechanism you're using.

Q Thank you. The next issue I would wish to go on to, and this is really the fourth issue that I raised at the start, and that is the remedial works carried out and the decision to open the hospital. The Inquiry has heard evidence that there is an escalation of NHS Lothian to Level 3 and then to Level 4. If I could ask you to look, please, to bundle 7, volume 1, and if we could look to page 293, please. So bundle 7, volume 1, page 293. So there's a framework set out here from Stage 1 to Stage 5. You see Stage 3 says, "Significant variation from plan; risks materializing; tailored support required." Then Stage 4 would be:

> "Significant risk to delivery, quality, financial performance or safety; senior level external support required."

Do you see that? For those of us not familiar with this escalation framework, could you perhaps just talk us through your understanding of what it is and what would have to happen for a board to be escalated to Stage 3,

Stage 4 and then ultimately to Stage 5?

A So, the escalation framework is essentially about the levels of direct support that Scottish Government or the Health Directorate believe a board needs from them in order to meet its targets and its obligations. So it sets itself out. It is self-explanatory. It is primarily-- In fact, it is not a decision of a cabinet secretary which level a board is at, with the exception of Stage 5, where there are, as it says, "Ministerial powers of intervention", very rarely used, in fact. Prior to that, it is a collective decision either by the senior management team in the Health Directorate or by the DG, him or herself.

In terms of Stage 3, it more or less tells you what is required. "Significant variation from plan" could be significant variation in terms of performance on waiting times, on other areas of performance, including financial performance. It could be where a board, in terms of mortality and morbidity stats, is an outlier compared to the rest of the country, and that then triggers the kind of support that it says. Stage 4 is where there are risks to delivery and that senior level support is required.

Q So, escalation to Level 3, that is not a decision directly taken by you as Cabinet Secretary, but presumably something that you are aware of.

A Yes.

Q Is it at that stage that the Oversight Board is created?

A It can be. I don't believe it is always the case an oversight board is created, but it can be, and I think in NHS Lothian's situation, it was escalated to Stage 3, at least in part, if not totally, from memory, because of performance on delivery targets, not specifically this project.

Q Okay, so the escalation to Level 3 is not specifically or only limited to the problems associated with the project?

A No, it's not.

Q If I could ask you to look to the terms of reference for the Oversight Board, so that is bundle 7, volume 2, at page 352. So bundle 7, volume 2, at page 352, so the terms of reference. If we could look on to page 354, please. See the background, section 2:

> "Following the decision to halt the planned move to the new Hospital facilities on 9 July an Oversight Board is being established to provide advice to

ministers on readiness of the facility to open and on migration of services to the new facility."

Do you see that?

A Yes.

Q Then towards the bottom of the page, we see the scope of work that is to be undertaken by the Oversight Board which includes "Advice on phased occupation". The final bullet point there says, "Identification of areas that could be done differently in the future". Do you see that?

A Yes.

Q The Inquiry has not seen any documentation suggesting that the Oversight reported on the identification of areas that could be done differently. Are you aware of why the Oversight Board did not report on those issues?

A Well, if I'm correct, NHS Lothian was escalated to Level 3 on 10 July or thereabouts, but raised to Level 4 on 13 September. So it is entirely possible that between 10 July and 13 September, that the Board in that sense had not got to that point. Further escalation arose, as I understand it, because by September we understood that there was more than ventilation in critical care to be addressed. There was also issues in theatre and in other areas. That was from the NSS report.

Q Again, the escalation to Level 4, a decision you are aware of but not a decision directly being taken by you as Cabinet Secretary.

A No, it's not.

Q If I could just ask you to look to bundle 7, please, volume 3, page 564, which is the letter of 13 September 2019. So bundle 7, volume 3, page 564, which is the letter of 13 September recording the escalation. If we look to the second full paragraph, it says:

"Having reviewed the contents of both reports that were published on Wednesday 11 September I have concluded, on the basis of scale of the challenge in delivering the Royal Hospital for Children and Young People, that NHS Lothian is escalated to Level 4 of our performance framework for this specific project. This level is defined as 'significant risks to delivery, quality, financial performance or safety; senior level external transformational support required."

Do you see that?

A Yes.

Q So the specific escalation to Level 4 is related to the project. Is

that right?

A Yes, it is.

Q It records that a senior programme director, Mary Morgan, is going to be appointed to assist with the project. So, in terms of the next stages in the project, is that really High Value Change Notice 107 and Settlement Agreement 2, which effectively are contracts to make sure that the ventilation system in critical care fully complies with IOM's interpretation of SHTM 03-01? Is that right?

A It is, as well as addressing the other matters that the NSS report raises.

Q Okay, and I will not take you through all of the Board minutes for the Oversight Board, but the Oversight Board meets on a regular basis. Can you just try to explain in this period of time, the Oversight Board is in place, you still have NHS Lothian, you have got the Oversight Board, the senior programme director, what is now being fed back to you? What is the role of Scottish Government in this phase on the project?

A So, what's being fed back to me is a report after every Oversight Board, and if there are any other issues between Board meetings, then that will be raised by me. At that point, I believe Professor McQueen is chairing the Oversight Board, so she would update me either verbally, but certainly there would always be a written report after each Oversight Board meeting.

Q Okay, thank you. If I could ask you to look to bundle 3, please, page 531, which is a minute of the Oversight Board dated 5 December 2019. Thank you. Do you see that?

A Yes.

Q Then if we could look over the page on to page 532 and to the first bullet point beginning, "The NHSL Board". So the minute states:

> "The NHSL Board had taken their governance responsibility seriously and whilst not happy about the current situation realised that this was the only option available to progress the opening of the hospital. The board reluctantly agreed the proposal.
>
> The NHSL Board had requested oversight board approval of the decision which they were agreeing to as it was appreciated that that the NHSL board would be signing the public sector up to unknown financial

risks, and currently no programme certainty associated with progressing with the proposal. They wished this concern to be made clear to the Scottish Government and Cabinet Secretary, given how the actions of the NHSL board may be viewed in the future."

Do you see that?

A Yes.

Q Do you remember this issue being escalated to you as Cabinet Secretary?

A Yes.

Q Can you just explain, what discussion is taking place here in this minute that is subsequently being escalated to you?

A So, what is being discussed there, and I would be aware of it before the Oversight Board, quite rightly, was what was necessary in order to pursue a programme of work with the relevant contractors and others to address the deficiencies in the build.

Q That could involve signing the public purse up to what is described there as "unknown financial risks"?

A Yes.

Q I appreciate that from the answers you have given earlier, you might not be able to comment on this in terms of the contractual structure, but the Inquiry has heard a lot of evidence about one of the benefits of the revenue-funded model, the NPD model, is meant to be that it places all of the design risk onto the private sector, so that is not borne by the public sector. The Inquiry has heard evidence that what really happens, in terms of High Value Change Notice 107 and Settlement Agreement 2, is that the original design team and contractor, they fall away. They are not willing to do those works. So effectively a lot of the risk that should, in an ideal world, sit with the private sector, that does not happen. Is that something that was being explained to you at this point in time, that the standard risk profile was going to change for the project?

A Yes.

Q Again, do you have any views in terms of whether that perhaps highlights problems with this type of structure that theoretically puts the risk onto the private sector, but in reality achieving that can be very difficult?

A Well, I can't comment as to whether it highlights problems with the overall approach. It certainly highlighted a problem here, but, again, in this situation, you're not looking

between a good option and a bad option. You're looking at what needs to be done in order to realise this building as a safe environment for patients and staff, given the level of investment that has already been made in it, versus not doing it.

I was of course acutely conscious that the additional cost of undertaking the work-- I'm not sure that was-- The view of unknown financial risk was the Board's view. I'm not sure that Scottish Government officials would've characterised it in that way, but there was a cost to fixing these problems. It was no longer one problem. There were a number of problems. There was a cost to that. There was also an associated cost of maintaining the Sciennes site and DCN and undertaking the additional works there that were required, and that had to come from the health budget, and I think, in one of the statements I made to Parliament, I was clear that we would not be looking to NHS Lothian for that additional money from their budget, but the overall health budget would have to pay and that meant that the consequence of that was that other areas where we might wish to spend money, we would not be spending money. So the overall health portfolio, if you like, was the loser here.

Q Thank you. The Inquiry has heard a lot of evidence about the works that are done, testing that is carried out in the period up to the hospital ultimately opening. Can you just perhaps explain to us, what updates are you provided with in terms of key stages to ensure that the hospital is safe, in your analysis, it complies with published guidance? What were you being told?

A So, I'm receiving, as I said, reports from every Oversight Board meeting, and when any of those reports or any of the information coming from Mary Morgan through Fiona McQueen to me is concerned with the validation and assurance of any of the work that's being done, then I am asking the question about who has validated that and assured us, and I'm also wanting to be sure, for example with DCN-- So, in terms of-- Once we were clearer about all the work that needed to be done and how long that might take-- of course COVID interrupted that, but how long that might take, we were looking to see whether it was possible to phase entry to allow DCN to move sooner than anywhere else, and what would that mean for the programme of remedial and improvement works that were needed?

I was keen that any move was one that the clinical teams were comfortable with. Not only that they were comfortable that where they were going was fit for purpose and safe, but also the manner in which the phasing was undertaken was one that they were agreeable to, in terms of the patients that they were caring for.

Q Thank you. If I could ask you to look within the Oversight Board minutes, please, to bundle 3, page 1095, which is a minute of the Oversight Board from 25 February 2021. So a minute of the Oversight Board on 25 February 2021, and then if we could look onto page 1097, please.

THE CHAIR: Thank you.

MR MACGREGOR: 1097, please, and it is the second last bullet point, beginning, "Ms Morgan outlined…" Do you see that?

A Yes.

Q

"Ms Morgan outlined that the last year had been spent correcting the pressure cascade in the new Hospital. In that period the Critical Care and Lochranza Ward Ventilation Systems had been rebuilt, CAMHS had been stripped out and reopened and all other items in the HFS report had been addressed. The new Hospital was now one of the safest and best buildings in the whole of Scotland."

Do you see that?

A Yes.

Q Do you recall that type of dialogue being fed back to you as Cabinet Secretary?

A Yes.

Q So, effectively, here there is-- the works have been carried out, HFS are involved in that and reporting on it, and Mary Morgan, the senior programme director, in her personal opinion, the hospital is now "one of the safest and best buildings in the whole of Scotland."

A Yes.

Q You address within your statement the fact that there is a phased opening of the hospitals. Can you just explain in your own words, why did you decide that these hospitals were now safe enough to open? What had changed from the point on 4 July?

A So, the issues that had been identified prior to 4 July, on the 2nd, and the subsequent issues that had been identified-- critical issues that had been identified in the NSS report, had all been addressed and

assurances had been received that they had been tested and validated and they met the required standards.

Q Thank you, and you mentioned, obviously, the particular difficulties associated with the DCN and the fact that there might need to be more of a move, and you mentioned the impact of COVID on potentially transferring. But for COVID, could the DCN potentially have opened at an earlier stage than it did?

A That's possible. COVID-- Although there was an exemption given to healthcare facilities in terms of the prohibition on construction, nonetheless, there were issues with supply chain during COVID in terms of some companies in the supply chain made the decision to furlough their staff, so they were no longer available. There were issues around social distancing during the COVID period, so you didn't have as many staff in a particular physical area as you might otherwise have. So that slows everything down. So COVID did have an impact in slowing down the work that was needed to be done to get the hospital to the standards that we required it.

Q Thank you, and you addressed the phased moves within your statement but, just to be clear, by the time you made the decision to open the hospital, did you have any concerns as to whether it failed to provide a suitable environment for safe, effective, patient-centred care?

A In terms of the built environment, no, I did not.

Q And is that as a result of all of the testing and assurances that you have outlined both in your evidence today and within your statements?

A Yes.

Q Thank you. I now want to move on and just ask you a few questions about NHS Scotland Assure. You have outlined, both in your statements and in your evidence, why you thought there was a need for a new centre of excellence, but before we come to that, if I could perhaps just ask you a few questions about Health Facilities Scotland. The Inquiry has heard evidence that Health Facilities Scotland, at the point in time that both the Royal Hospital for Children & Young People and the Department for Clinical Neurosciences and the Queen Elizabeth University Hospital were being built, that there was only one engineer that was actually within Health Facilities Scotland. Do you think that was problematic?

A Yes, I would think it would be, yes.

Q And what do you think were some of the challenges that faced HFS because it only had one engineer working in it at that time?

A Well, during that period, we were asking them to focus and do a fair amount of work on the issues around Queen Elizabeth. So they were focused in that direction and then there was also the situation here with this hospital. So they were stretched, I would have said.

Q So, in terms of the new centre for excellence, was one issue that was going to have to be addressed resourcing?

A Yes, I believe so, but the point-- from my mind, the point of what was initially described as the new centre of excellence, now NHS Scotland Assure, was, as I've said in my statement-- So it is unlikely that, during the tenure of a chief executive of a health board, that they will have more than one major project like this one to oversee and take final responsibility for. That applies to their teams as well, and some of them will go through their entire tenure with no such responsibility. They're not appointed for their skillset that is about leading a major build of a healthcare facility.

So it seemed to me a degree unfair to expect a great deal from them in terms of construction, technical expertise and so on, without providing them with a central resource that they could draw on that had that expertise but also, by being a central resource, could look to continuous improvement, could look elsewhere beyond Scotland to the rest of the UK, to Europe and elsewhere, to comparable systems, and learn lessons and implement improvements, and perhaps contribute to good practice elsewhere as well. So that was my thinking behind-- In a country of 5 million, just over 5 million, we don't need to keep replicating this exercise over and over again every time we have a major build. Why don't we centralise the expertise that is then there for any health board to draw on when it is their time to undertake a major healthcare development like this one?

Q So, is one of your reflections that there really needs to be greater standardisation in terms of healthcare buildings?

A I think one of my reflections is that we need to be absolutely certain that, from design all the way through every stage, to delivery, best practice on infection

prevention and control is in the built environment. That it is, of course, around the expertise and experience of staff at every level in healthcare to practice and deliver effective infection prevention and control, bearing in mind that you cannot guarantee no infection, but the built environment is critical to that.

Q And in terms of just thinking about that issue, if you are in a health board, a new-build hospital might be either a once or a never in a career event, do you think it is realistic to ask those individuals to take forward these types of projects or should there really be a central building division within the NHS?

A So, there you are touching upon what I described earlier as the balance that needs to be struck between the statutory responsibility of individual territorial health boards and any central facility, and that, I think, is an area that has not had sufficient attention and discussion. I'm not proposing a solution to that at all. I don't believe I am qualified to do so without that consideration and discussion but I don't think we can continue to pretend that that tension isn't there.

I think part of my reasoning for what is now NHS Scotland Assure was

to try and find one way to provide health boards with expertise and skill that they could use. I don't mean any disrespect to independent technical advisors, independent design teams, construction, but if you are in a health board because you are the medical director or the chief executive or the chief finance officer or whatever you might be, you have an important skillset and set of experience but your capacity to challenge what a technical expert is telling you is reasonably limited. That's not your area of expertise. You need an equivalent area of expertise to be doing that questioning and challenge, and arguably you might not need as much in the way of independent expertise and advisors to be brought in to make up for what you don't have because you have this centre. So that was my thinking behind this.

Q So, NHS Scotland Assure may be part of the solution but it might not be the totality of the solution for some of the issues you have just touched upon?

A I don't believe it is the totality of the solution, no.

Q Thank you. Lord Brodie, I am conscious that that is just after one o'clock. I do not have much further to go but I would not be

confident of finishing in the next 10 to 15 minutes so that may be an appropriate point to take a break.

THE CHAIR: Yes, I can understand that, Mr MacGregor. We will take an hour for lunch, so if you could be back for about five past two.

THE WITNESS: Yes.

THE CHAIR: Thank you.

THE WITNESS: Thank you.

(Adjourned for a short time)

THE CHAIR: Good afternoon.

THE WITNESS: Good afternoon.

THE CHAIR: Mr MacGregor?

MR MACGREGOR: Thank you, Lord Brodie. Ms Freeman, just before lunch we were discussing NHS Scotland Assure and you said you did not think that it was the complete answer to the problems that had arisen on the project, and we discussed some of the options in terms of taking that discussion forward and you said that you did not think you were really best placed to say what the ideal solution would be. I would just be interested in your views. If there was a discussion that had to take place around, how should things be done differently and how do we really cure this problem, who needs to be involved in that discussion to shape the future?

A So, I think certainly Scottish Government does and arguably should lead to that discussion or initiate it, but it would be more than the health department. I think Scottish Government finance, the overall finance function, because one element of it of course is whatever funding mechanism or elements of funding mechanism might be settled upon, that would have a wider implication than health infrastructure. It would potentially apply to all public infrastructure.

In terms of health, the boards themselves, but also I think we have Royal Colleges that are representative of clinical expertise in various areas. It would need legal advice about what might be any legal underpinning to a new arrangement and what might need to change in current arrangements in order to allow any new arrangement to be in place. Just on the question of the infrastructure and the build, you've obviously got NHS Scotland Assure, but you have other areas of expertise within the health service and external to it.

And I always think it's-- If you're looking at how might you, in the round, do things better then it's wise to look at how other countries do it, including other parts-- other nations in the UK,

as well as elsewhere. You're looking at comparable countries and how do they organise matters and conduct these arrangements, and then see what might be possible.

Q Thank you, and in terms of your vision for NHS Scotland Assure, you were very clear in your evidence earlier today that you thought there had to be a physical inspection element to that, whether that is done by Assure or whether that is provided to Assure, but there has to be those physical checks that were done. In relation to NHS Scotland Assure, you have touched upon the issues about the legal framework that currently exists. Because of that existing framework, did you always anticipate that NHS Scotland Assure would have an oversight role in these projects as opposed to taking actual responsibility for aspects of the projects?

A Yes. Well, within the current arrangements I could not see how they could take actual responsibility for the projects because of the legal position of boards, as we've discussed, but I wanted their role and the use of NHS Scotland Assure to be more than voluntary. I wanted it to be a requirement that they were involved in everything about the build of healthcare facilities, from

design right through, and therefore there needed to be different bits of NHS Scotland Assure.

I took the point-- Although the discussions I had were fairly early on before I stepped down. I took the point about being regulatory or not, and not over-regulating matters, but that is not the same as a Scottish Cabinet Secretary looking to NHS Scotland Assure for assurance that they can give or not give, but based on their expertise in whatever particular area it was, and their commissioning of actual testing of facilities, as you say. Whether they do it or whether they get someone independent to do it who's expert in whatever that area might be, that they can say, "Yes, ventilation, it does meet a standard. We have that assurance, and it has been tested as such."

Q Was there any thought given to whether the new body, the new centre for excellence, should have a regulatory function like the Health and Safety Executive that went in and did physical inspections and signed matters off, or was that not something that was considered?

A Not whilst I was in office, because we were dealing with all of this, of course, in 2019 and then throughout, but the bulk of my

attention from 2020 onwards was on COVID and our response to that pandemic, and that was the case for the vast majority of officials, including senior advisors in the Health Directorate. So there was a lot-- Although it appeared as a commitment to establish such a body in the programme for government in 2019, there was a lot to flesh out, and the nature of things is such that I wasn't overly involved before I resigned, in the fleshing out.

Q Okay. If I could ask you to look to the Target Operating Model for the new centre of excellence, which is in bundle 9, page 4. Were you aware of being involved in the discussions around the Target Operating Model before you demitted office?

A I don't recall that.

Q Okay. I will just ask you to look at some aspects. If you cannot assist the Inquiry, then please just do say so.

A Sure.

Q But if we could look on, please, to page 12. You will see that there had been research carried out, and the research is recorded here. So it says:

> "Our Research. The user research sought to understand users' experiences, pain points of managing risk in the healthcare built environment, and what they want and need from the QHBE."

Do you see that?

A Yes, I do.

Q And then there are the key themes. If you pick matters up approximately halfway down the page, "Skills and training" is highlighted:

> "Having experts available at the right points in the process, i.e. IPC, Estates and Executives. National and local…"

Then it says, "Procurement, Guidance, Change control and Governance", and you see at the bottom of the page it says, "A full summary of user research key insights can be found at Appendix A." And then if we look onto page 59, we will see the user research, and it was just to pick matters up in the bottom box, which is headed "Procurement." Do you see that?

Q Yes.

A So, it says, "Procurement. Current procurement processes are not fit for purpose." Do you see that?

Q Yes.

A Do you understand what that means, what the user research was showing there?

Q On the basis of that sentence, no, I don't. There could be a number of interpretations of that.

A What were your views on the procurement processes for these new-build hospitals? Did you think they were fit for purpose?

Q I was not overly familiar with those, and, in fact, during my term of office, I don't believe there were any new builds begun that would be at procurement stage. They were all in train when I became the Health Secretary, and any new ones coming down the line had not really begun.

A Presumably, you make the fair point that really the centre of excellence that is established in the Programme for Governance while you are still Cabinet Secretary, and then you leave office and it would be for others to take that model forward. Presumably, if NHS National Services Scotland has identified through user research that procurement is an issue and that the current procurement process wasn't fit for purpose, you would expect the Scottish Government to pick up on that and try to resolve any issues?

A Well, yes. I would expect more information about, well, what actually were they saying? That's a a synthesis of what was said, so what-- in what way are the current processes not fit for purpose? And then a discussion about whether or not that can be remedied and improved.

Q And then, if we look to the next bullet point, it says, “Boards do not have ability to check what contractors are delivering.” Do you see that?

A Yes, I do.

Q And, again, this is perhaps an issue that a number of individuals that have given evidence to the Inquiry have highlighted, that you have a very simplistic model on one view, whereby there is the project agreement between the Health Board and the project company, but actually there is a web of contracts that sit below that, that the project company enters into, and you have the Health Board sitting really as a third party. They are very interested in what is delivered under these contracts, but they do not actually have any direct contractual relationship with the parties carrying out the works. Do you think that that is a problem in these types of revenue-funded projects?

A I can see that it can be. However, if we go back to what I said earlier, part of what I envisaged NHS Scotland Assure being able to do is – as I think they actually say on their

website – align compliance with guidance from procurement all the way through. So that's where the expertise can come from.

So, I'm not expecting a member of a health board to be the one to go around flicking the switches and pressing the buttons, not least because they have got a great deal else that is important that they do, but I would-- That is why, is one of the reasons why I thought NHS Scotland Assure was a good proposition, and I think as it says in some of-- either there or in what you showed me earlier, almost a good proposition for all health boards, but particularly in some instances for the smaller ones, where they have less in-house expertise to draw on.

Q Thank you, and then if I can ask you to look over the page, please, to page 60, you will see the top box says “Guidance”, and then in terms of insights, it says:

> “ Guidance needs more teeth. Guidance needs to be clarified and when it's applicable in full or where appropriate there needs to be support on how to translate guidance in practice.”

Do you see that?

A Yes, I do.

Q In terms of this issue of guidance not having teeth, if your view is guidance equates with a base level of safety that would be expected in a modern healthcare facility, why are we actually talking about guidance? Why are we not talking about a hard-edged legal standard like you would see in the building regulations, with the Technical Standards Handbook that sits with it? You do not need to do that for every health facility. That might be impossible for old Victorian buildings, but why are we talking about guidance? If the guidance needs more teeth, why did the Scottish Government not simply say, “We need a hard-edged legal standard for new-build hospitals for critical building systems”?

Q Well, during the period when I was in office, it was not appropriate at that point, on the basis of all that I knew, to say with absolute certainty we need a hard-edged standard, or guidance with teeth, if you like. My view would be that where we have best practice guidance, that it should be mandatory, unless there is evidence to make it exceptional in particular circumstances, and those would be circumstance by circumstance. That’s my personal view. Whether or not government currently is seeking to give guidance

more teeth, I can't comment.

A No. That is understandable, and, again, you might not be able to comment on this, but the Inquiry has heard evidence from expert engineers who have said that in England and Wales, there is a procedure whereby you have the building regulations and then you have a set of documents called the approved documents. If you comply with the approved documents, you are complying with the building regulations, and the health technical memorandum, so the English equivalent of SHTM 03-01, it sits as an approved document. Your personal view, not your view as a member of the Scottish Government, but, in your view, would that type of model be something that may merit consideration?

A Yes.

Q In relation to potential reflections, we have discussed the issue of revenue-funded projects. We have said fairly that you are not really clear that you are the best person to talk about whether capital and build or revenue-funded is the best model. Do you think one way of simplifying matters though, would be to give health boards the ability to borrow funds? So that rather than having to have a revenue-funded model, they could simply borrow the money they needed, build their healthcare facility, and then you do not get into PFI, PPI, revenue-funded, NPD. It would be a much simpler model for the healthcare provider.

A No. I think a simpler model would be to give the Scottish Government the capacity to borrow funds greater than they currently have. Of course, a straightforward capital-funded project from government is simpler, clearer, arguably then easier to manage. It does not negate the need for the practice of governance, as we've discussed earlier, in any respect, nor does it negate the need for something like NHS Scotland Assure, but it is more straightforward. But in circumstances where that capital is not available, and there is no capacity for government to borrow, to secure additional capital, then when, on the other hand, you're faced with a need to procure improved environments for healthcare, then governments reasonably look at other models.

But I think if you want to increase the borrowing powers of anybody, you increase the borrowing powers of the Scottish Government, because it as a whole is accountable to the Scottish

public, and what you're talking about is public money, because borrowing money has to be paid and that gets paid from the public purse. So I don't think it is the right answer to give those additional powers to individual health boards, but I think there is a strong case for the Scottish Government to be able to borrow funds for those purposes.

A Thank you. I would like to ask you about a slightly different area, and that is about the amount of robust scientific data there is that sits below published guidance, particularly SHTM 03-01, and if I could perhaps begin by asking you to look to bundle 13, volume 3, at page 553. So bundle 13, volume 3, page 553. So, this is an older iteration of Scottish Health Facilities Note 30, Version 3. So this is the 2007 version, not the 2014 version that is currently in force, and if I could invite your attention on, please, to page 576, and the conclusion section at page 5.19. This was NHS NSS's position in 2007. It said:

> "The integration of prevention and control of infection risk management and construction is in its infancy. It represents a significant change in the management of healthcare facilities design and planning which will take time to develop to a level at which the greatest benefits can be achieved. Just as important then is the need to carry out research in the area of risk management, prevention and control of infection and the built environment to produce sound, irrefutable evidence on which to base further risk management strategies."

Do you see that?

A Yes.

Q So, 2007, an identified need for further research to be carried out in this area. If I could then ask you to please look to bundle 3 and to page 185. Bundle 3, page 185, which is an NSS report into the Royal Hospital for Children & Young People and the Department of Clinical Neurosciences from 9 September 2019, and if we could look onto page 199, please, into paragraph 4.2.6. So what is stated in the NSS report is:

> "From an infection prevention and control perspective, there is low-quality to no evidence from outbreak reports and current guidance, respectively, to support minimum ventilation requirements. Therefore, it is not possible to make conclusive statements

regarding the individual minimum ventilation parameters for inpatient care areas. A rapid review of the literature found limited clinical evidence to directly implicate air change rates alone in having a direct impact on the development of an outbreak or incidence of infection. Therefore, it is reasonable that, in the absence of evidence, healthcare design teams should continue to adhere to current national guidance.

In the event of a deviation from the current recommended ventilation parameters, design teams should ensure that air changes per hour are maintained as close as possible to the recommended air changes per hour without compromising other aspects of the ventilation system requirements. In addition a full assessment of the services and patient population should be carried out and mechanisms for monitoring established. Caution is advised in relying on air change rates alone to provide adequate protection from infection; this is only one part of a multifactorial process involved in creating the appropriate airflow patterns with appropriate mixing and dilution of contaminants.

Nationally, further research is required to look beyond air change rates to examine the effects and other factors such as supply and exhaust location, door position and motion, spatial orientation, surface composition, temperature, humidity, and air distribution patterns have on particle migration in clinical areas."

Do you see that?

A Yes.

Q So, 2019, there is a suggestion that really there is still poor quality data and further research required. Did the Scottish Government instruct any further research to be carried out in terms of the link between air changes and ventilation in relation to potential adverse clinical outcomes?

A I'm afraid I can't answer that. It would be for primarily the Chief Nursing Officer Directorate to pick that up, but of course this is September 2019. By January 2020, we were dealing with COVID, and so that may have been an intention. I don't know. You'd need to ask other witnesses of that. Even if that had been the intention, it is possible, entirely reasonable I would think, that it would

not necessarily have been pursued, given the entirety of our NHS, but that includes our healthcare directorate and government, pivoted towards dealing with the pandemic.

Q Entirely understandable, and you then leave office as Cabinet Secretary thereafter.

A Yes.

Q Really just asking for your observations, 2007, the guidance is saying there needs to be more research in this area. 2019, NSS are saying there needs to be more research in this area. If that research has not been instructed, do you think it now should be instructed?

A Yes, I do, because I always think it's important to look for as much evidence as you can find to improve your learning and your understanding of any situation. Of course, the absence of that research, if indeed there is an absence of research and it's not currently being undertaken, and I do not know, doesn't negate, as indeed that paragraph says, the requirement to adhere to what is considered at the time as best practice. The paragraph rightly points out that of course ventilation is not the be-all and end-all in the built environment in terms of infection prevention and control, but it is a critical element.

Q Thank you. Final issue I wish to ask you about at this stage is, if I could ask you to have your witness statement in front of you, please, and if we could look to page 211 and paragraph 170. Page 211, paragraph 170. You tell the Inquiry at paragraph 170:

> "I think the Scottish Government has to move away from a notion of being arm's length to all of this, facilitating the funding, but basically leaving it then to boards to get on with it. I think that's unrealistic but also wrong."

Do you see that?

A Yes.

Q Now, we have talked about the discussion that generally maybe needs to take place, but in terms of the specifics, if there is going to be a change, what should Scottish Government be doing in the future that it has not been doing in the past in these projects?

A Well, I think NHS Scotland Assure is part of what should be done. My own view, as we've touched on, is that I do think there needs to be consideration given and discussion given to whether or not there is more that can be done to

rebalance the relationship between Scottish Government and health boards without necessarily changing the legislative basis on which health boards exist, but also considering whether that is necessary.

For the reasons that I state and I've outlined earlier, as far as the public of Scotland are concerned, I believe, and I believe it is entirely reasonable, they elect MSPs to represent them. From that, a government is formed, and individuals are given the honour and privilege of holding cabinet positions. That means you are accountable. You cannot be accountable for something that you are not, as I say here, in the loop on. You absolutely should be accountable. What you do should be scrutinised and challenged, but to make that fair, you need to be involved.

Now, that doesn't mean that a Cabinet Secretary should effectively be micro-managing every aspect of healthcare or every health board. That would seem to me to be foolish, but you can't have an arm's length position on something as fundamental to patient safety as infection prevention and control, which is fundamental in the built environment. I think those are really important lessons. The built environment can't be ignored when you talk about patient safety. It is critical to it. It's not exclusive, but it is critical.

Q Thank you. Ms Freeman, the final question for me at the moment really is an open one. Obviously, you have had a lot of time to reflect on the project, the Royal Hospital for Children & Young People. We have covered a lot today. You have covered a lot in your two statements. Do you have any other reflections in terms of how these types of projects, new-build hospitals, can be done better in the future to try to avoid some of the issues that cropped up on the project?

A I don't believe I do, other than what I have said today about what I think should be considered, researched, worked through further. Of course, I am mindful that in saying all of that I'm not the one who's going to be doing it, and that's a relatively privileged position to be in, but that would be my view. The areas that we've touched on today are the ones I think need to be considered further.

Q Thank you. Ms Freeman, thank you for answering my questions today. I don't have any further questions at this stage.

A Thank you.

Q Lord Brodie may have

questions, or equally there may be applications from core participants, but thank you for answering my questions.

A Thank you.

Questioned by the Chair

Q Ms Freeman, really just on that last point, I think you have got the distance of saying you see a need to rebalance the relationship between Scottish ministers and the Health Board. Now, as you have explained to us, the 1978 Act imposes an obligation on Scottish ministers----

A Yes.

Q -- to, I think, promote a health service in Scotland. Now, what I am interested in is frankly the mechanics of rebalancing. You do not go the distance of saying that there is a requirement to change the legislation. Is it simply a matter for Scottish ministers' decision to make a more proactive or-- I am trying to avoid the word "aggressive", but I think you will perhaps follow my thinking. Is it simply a question of Scottish ministers deciding to take a more – I will use the word "proactive" – approach to the use of existing powers? Is that what you have in mind?

A So, first of all, I'm not saying categorically that the legislation should not be looked at. What I'm saying is that that may be necessary, but you need to have the full consideration of all of the factors before you would reach that point. So, there is, in my view, an imbalance in Scottish ministers being accountable in this area, in terms of the delivery of healthcare, where in certain critical aspects of that – here we're talking about the built environment – Scottish ministers are arm's length from some of the critical decisions that get taken. (Inaudible) assurance required in securing a built environment that is as safe as it can be for patient care. There's an imbalance there and being accountable for something when you are at arm's length from it.

Equally, there is a value in the local nature of our health boards, and so I'm not suggesting centralising how we deliver healthcare. Part of how I think we redress that balance is through the creation of NHS Scotland Assure in the way that I envisaged it and described it, where it sits, if you like, as the arm of independent assurance to government ministers about those critical decisions having been made. It has some of its processes, the KSAR and others, that allow it to be at the table at those

critical points, and therefore it should be able to give Scottish Government and Scottish ministers the assurances that are necessary.

Whether there is more that needs to be done, I genuinely do not know, but my mind would not be closed to further consideration of whether there is more that needs to be done and, as part of that, whether or not there needs to be some amendment to that 1978 Act that gives Scottish ministers more powers, rather than the exercise of the powers that Scottish ministers do have and which I used during COVID, which is to put the NHS on an emergency footing. That is not something you want to be doing every day, but there may be some amendment needed to that legislation. Without full consideration and thorough discussion involving all of those parties I mentioned earlier, I couldn't reach a view on that at this point.

Q Thank you, Ms Freeman. Now, Mr MacGregor has indicated that he has no more questions for you, but I want to just check with the room, as it were, if there are any other relevant questions that might be asked. Now, what that will involve is I will rise for about 10 minutes. Depending on discussion through Mr MacGregor, I will ask you to come back and either tell you there are more questions or there are no more questions. So if I could ask you to retire to the witness room.

THE WITNESS: Of course. Of course.

(Short break)

THE CHAIR: Mr MacGregor.

MR MACGREGOR: No further questions, my Lord.

THE CHAIR: Oh, right. Ms Freeman, I am advised there are no further questions, so that means you are free to go, but before you go, can I thank you for your attendance today and for the work involved in preparing your statements. I appreciate that would have been considerable. Thank you and, as I say, you are free to go.

THE WITNESS: Thank you very much, my Lord. Thank you.

THE CHAIR: Now, as I understand it, Mr MacGregor, you do not have another witness today, but Mr Maddocks will be with us tomorrow?

MR MACGREGOR: Yes, my Lord. Mr Maddocks first thing and then Mr Morrison after that tomorrow.

THE CHAIR: All right, so we would hope to take two witnesses tomorrow?

MR MACGREGOR: Yes, my

Lord.

THE CHAIR: All right. Very well. Well, we will see each other tomorrow, all being well.

(Session ends)

14.50