SCOTTISH HOSPITALS INQUIRY

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Hearings Commencing
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Day 8
Thursday, 7 March 2024
Alex McMahon
John Connaghan
Fiona McQueen
Mary Morgan

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9:32

THE CHAIR: Good morning. Now, Mr MacGregor, Professor McMahon?

MR MACGREGOR: Yes, my Lord.

THE CHAIR: Carol, do you want to maybe just confirm with-- Oh, okay. Good morning. Good morning, Professor McMahon.

THE WITNESS: Morning.

THE CHAIR: Now, as you appreciate, you are about to be asked questions by Mr MacGregor, who is sitting opposite, but first I understand you are prepared to take the oath?

THE WITNESS: I am.

Mr Alex McMahon

Sworn

THE CHAIR: Thank you very much, Mr McMahon. Mr MacGregor?

Questioned by Mr MacGregor

Q Thank you. You are Professor Alexander McMahon. Is that correct?

A That's right.

Q And you have provided a witness statement to the Inquiry?

A I have.

Q For the benefit of core participants, that can be found at pages 106 to 115. 115, bundle 1 of the witness statements. Professor McMahon, the content of that witness statement is going to form part of your evidence today, but I am also going to ask you some questions. If you want to refer to your witness statement at any point, a copy will be provided to you. If I want to take you to any documents, those should come up on the big screen in front of you. If for any reason you cannot see the documents or you cannot find the part that I am referring to, please just do let me know. I think that there is a correction that you wanted to make----

A Yes.

Q -- to your statement, so if we could perhaps just bring your statement up. So if we look within bundle 1 of the witness statements and look onto paragraph 6, please. So page 107 and paragraph 6. So you tell us in paragraph 6:

> "I have been asked when I became involved in the Royal Hospital for Children & Young People/Department of Clinical Neuroscience (RCHP/DCN) Project (the 'Project'). My direct involvement started around May/June 2019 in my capacity as the Executive Lead for IPC."

Do you see that?

A Yeah.

Q Is there anything you want to correct in that statement?

A The sentence, "IPC became part of my responsibility from March 2019," that should be March '18.

Q March '18, okay, and if I could perhaps just ask you to look back, just so the Inquiry can understand exactly what your responsibilities were, at paragraph 3, I think you set out some of your responsibilities when you were working within NHS Lothian. So if we could just look to that one on page 106. You say:

> "I joined NHS Lothian as Deputy Director of Strategic Planning and Modernisation in September 2008 and was then appointed as Interim Director in October 2009. From 2012 onwards, I was the Director of Strategic Planning, Performance and Information. In 2016 I was appointed the Executive Director for Nursing, Midwifery and Allied Health Professionals in NHS Lothian. In addition to this, I also had wider management responsibilities, including management responsibility, for the infection prevention and control (IPC) function. That became part of my remit during 2019."

Do you see that?

A 2018.

Q So that should be '18?

A Yeah.

Q So, again, it is just obviously a typographical error, but just so I am understanding things, throughout 2018 you have a responsibility for infection prevention and control as opposed to in 2019?

A It became part of my responsibility in '18, yeah.

Q Thank you. So, I think we have, helpfully with those corrections, covered off a lot of your qualifications and experience, but you set those out within your statement. By way of a broad summary, you qualified as a nurse in the 1980s. Is that correct?

A Yes.

Q And in your career, you have worked in the NHS, in industry and in government?

A Yeah.

Q You joined NHS Lothian in 2008, and as we see from your statement, you have had various roles there. Is that correct?

A Yes.

Q In 2016, you were appointed as executive director of nursing, midwifery and allied health professionals for NHS Lothian. Could you just explain, in broad terms, what did that role involve?

A So, as an executive director, you're actually appointed by the Cabinet Secretary into that post, so there's only a small number of directors who have executive status. It involved responsibilities, it says here, for nursing, midwifery and allied healthcare professionals, physiotherapists, occupational therapists and others, in a professional capacity. I also had responsibility for other functions such as our complaints function, management of the Royal Edinburgh Hospital, which is in healthcare, for example. So quite a broad range of operational and professional responsibilities.

Q Thank you, and you say you were at the director level. If we are just thinking about the involvement that you would have in infection prevention and control, the Inquiry has heard from a range of infection prevention and control professionals: Sarah Jane Sutherland, who was an infection prevention and control nurse; Lindsay Guthrie, again, who was an infection prevention and control nurse;

Dr Inverarity, who is an infection prevention and control doctor. Are you, effectively, sitting above them at director level? Is that correct?

A Yes. I mean, when I took it on, there was actually someone between me and them. So, yeah, I was above them.

Q So you, effectively, have the director responsibility, almost a management function, but you are not doing the granular day-to-day activities of an infection prevention and control professional?

A I mean, the role actually required you to have a responsibility across the totality of NHS Lothian without necessarily having managerial responsibility for certain functions. So usually there's many people at director levels sitting below me or head of service level who managed a lot of those services.

Q Okay. So we will come on and look at concerns that Dr Inverarity had in particular, but, again, just to try and understand the chain of command. If an IPCN or an IPCD, they have certain concerns that they want to escalate up within an NHS organisation, can you just try and explain, in your own words, how serious does an issue have to be before it gets up to your level, at

director level?

A So, obviously, within my statement and through the Inquiry, issues were starting to be raised towards the spring and summer of '19 because there was anxiety being expressed about a process. So that's the kind of example where-- day-to-day stuff would not be raised with me, you know, an incident for example. DCN's a good example of that, where there was pseudomonas. I actually stepped in eventually to take the leadership role around managing those incidents because, for example, I was freeing up Dr Inverarity to do the work that he had to do but, you know, it would have to be fairly significant to have a-- to be brought to my attention.

Q Okay. So, relatively significant issues for something to be coming onto your radar. So, again, just so I am understanding things, if we see you being copied into email chains, for example, that is because whatever is being discussed, that is a relatively significant issue if an IPCN or an IPCD are wanting to include you within the email chains?

A On the whole, yes. I mean, sometimes it would just be for information.

Q Thank you. That obviously deals with the role that you had within NHS Lothian. You tell us within the statement since 2021 you have been the chief nursing officer for Scotland. What does that role involve?

A So, I have professional responsibility in relation to nursing, all matters related to nursing for Scottish Government ministers. So I'm their key advisor in that regard, but the directorate that I have responsibility also covers professional responsibility for midwifery, all of the health-- allied health profession disciplines and health science disciplines as well. So there's quite an expanse of professional responsibility across all of those disciplines. I also cover a number of policy areas as well, one of which is hospital associated infection and also regulation of all health disciplines: doctors, dentists, pharmacists, etc., as well. So as well as being the chief nursing officer, I also have the status of director. So I have a directorate that manages the work on a day-to-day basis, and as director, I sit at the management board of NHS Scotland within the department.

Q Okay. Thank you. So a range of activities including responsibility for policy in the most general sense for nursing. So if we

are thinking about high level issues about resourcing within the nursing profession, training of the nursing profession, are those the types of high level issues that would be on your agenda?

A Yes, my directorate has responsibility for controlling the number of student nurses we would recruit on an annual basis, for example, number of midwives, and actually working with the council of deans of universities, so the education of nurses, midwives and others too.

Q Okay, thank you. Now, I want to ask you some specific questions about your involvement in the Royal Hospital for Children & Young People and the Department of Clinical Neurosciences. I am just going to refer to that as "the project," that is the shorthand that I will use, and you tell us within your statement you become involved because there is increasing concerns that an HAI-SCRIBE procedure has not been completed. We will look at some of the documents, but just in very general terms, just explain how you become involved in the project.

A So probably around about March '19, Donald Inverarity, I think on the back of an IMT that we were having in relation to the Western

General issue, raised a point that he hadn't received documentation around the elements of ventilation. So that was a flag that had gone up at that point and obviously we took some actions in relation to that, both seeking some assurance from the project team and ultimately actually doing a physical walk around the building. So that was a kind of issue at that point, and then around about May time, Fiona Cameron, who was the head of Infection Prevention Control, actually raised concern again the process around HAI-SCRIBE wasn't complete and we were obviously getting closer to the occupation of the building.

Q Again, the communications-- So, obviously a continuum over a period of time, but how concerned is Dr Inverarity in particular in the communications and discussions that he is having with you?

A Yeah. I mean, I think if you looked at the email chains, Donald did raise concerns, I think, given the need to undertake the validation work that was going to be required, and the fact that the hospital was actually occupied at that point meant that we couldn't do some of that validation because it had to be empty or near empty in order to do the testing robustly, in order to meet the

requirements of the HAI-SCRIBE.

Q Dr Inverarity, whenever he gave his evidence, he described that really as being a safety issue. If you do not do the full HAI-SCRIBE, you are missing a chance to finally check that the hospital is safe. Is that the type of communications that you were having with Dr Inverarity?

A Yeah, and obviously with others within the project team as well at that stage, certainly March onwards because, you know, it wasn't just for Donald and I to raise that issue, it was for myself and others to kind of ensure that we were doing what was required. Unfortunately, we couldn't do what was required because we couldn't actually access the building because it was still a building site.

Q Yes. Again, if we just think about what you have told us about the fact that you take over responsibility for infection prevention and control at the highest level, and you have that responsibility 2018 through 2019. The Inquiry has heard evidence that throughout 2018, NHS Lothian is involved in discussions with the project company, IHSL, about potential changes to the specification for the ventilation system.

Now, we do not need to get bogged down on whether that is a change to the brief or a change to the design, but there is polarised views as to what the ventilation system should be doing. On the one hand, one party is saying, "Balanced or negative pressure, four air changes per hour," the other party is saying, "No, no, it is positive pressure, four air changes per hour," and that issue in 2018 is at the point that NHS Lothian is thinking about raising court proceedings, thinking about litigating to compel IHSL to provide balanced or negative pressure. Are you aware that those discussions are taking place in 2018?

A Peripherally. I mean, obviously, as an executive director, I attend the Board meeting and some of the other committees, but I can't remember that level of detail being discussed around ventilation.

Q The evidence that the Inquiry has had from Lindsay Guthrie, from Dr Inverarity is that those discussions are taking place about what the technical requirements should be for the ventilation system with a very specific set of requirements being put forward by NHS Lothian, with NHS Lothian saying if the project company does not provide those they will go to court and compel them to do it. They say that they did not have any involvement whatsoever in the

discussions that are taking place. Apart from having updates at the highest level at the Board of NHS Lothian, should the Inquiry understand that you are not having any involvement in those types of discussions?

A No.

Q Just standing back from that and thinking about the role that you had, you have a critical building system potentially linked to patient safety. Can you give the Inquiry an explanation as to why Infection Prevention and Control within NHS Lothian, they are not involved in those discussions?

A So, it's part of the process that there are-- or there was an infection control nurse and microbiologist working with the project team, and, again, through the line of command, assumptions were probably made that those individuals were playing into discussions and given nothing coming up the line. Certainly, to me, there was no requirement to step in at that point or to be involved in discussions.

Q So, again, it is not criticism of anyone, but just to understand factually: there is effectively an assumption that any Infection Prevention and Control input would have been had at an earlier point in time.

A Yes.

Q And, as a matter of fact, as you understand it, there was not any Infection Prevention and Control input in the discussions that are taking place through 2018 right up to the agreement that is signed in 2019.

A Not that I'm aware of, no.

Q Okay. One of the reasons that I raise this, and I would be interested in your views, if we think that there is going to be project agreement that has a set requirement, okay, so whenever you sign a contract, whatever it means – and people can argue about that – there is a set requirement. It would mean something. It would have a legal meaning. You then have a set of discussions whereby there is going to be a change, or it is going to be made absolutely clear just exactly what the requirements are. If there is going to be a potential change to the requirements, to the specification for a critical building system, be it water or ventilation, in that HAI-SCRIBE procedure, should the clock not be wound back? You should not be thinking about Stage 4 or final sign-off; you should actually be looking at Stage 2, a review of the design or the

brief. Would that be your understanding?

A With hindsight, perhaps, but I guess at that stage that wasn't any advice that we were being given. The advice at the time was to progress to HAI-SCRIBE Level 4, because we were obviously progressing towards completion and opening.

Q I guess we are looking back with hindsight, and that is completely understandable. A range of individuals have given justifications from a commercial perspective in particular why it would have been ideal to have followed due process, but it perhaps could not be done. But if we are just thinking at a level of generality on a building project, if you have a brief and you are then thinking about changing that brief, as opposed to simply steaming on in the HAI-SCRIBE process, should you actually be winding back and going back to Stage 2, which talks about reviewing the design?

A I suppose like every project, if there was any change that was material, there should have been a risk assessment done to decide whether or not stepping back in the process was required or not.

Q And, again, if we are just thinking generally, if we think about

some of the mandatory documentation within the NHS, things like SHFN 30, you presumably have a general familiarity with that document, although it is perhaps not a tool that you use at a granular level; but you will be aware at a policy level it talks about a partnership approach to projects. So healthcare-acquired infections, infection prevention and control, yes, it is important for infection prevention and control professionals, but it should also be on the radar of Estates teams, contractors, clinicians. Again, just thinking broadly, if you do not have an infection prevention and control individual as part of the team that is involved in the discussions through 2018, is that a potential skills gap given what SHFN 30 tells us about the partnership approach?

A So I wasn't aware of any skills gap, but you're right that the process requires all parties to play in because the IPCN role was only one role within that, so I wasn't aware of any issues being flagged that there wasn't participation, for example, of IPCN into that process.

Q If there was not participation of the IPCN in the process through 2018 whenever the changes are being discussed, in your analysis, would that be a failure? It is

a failure to comply at least with the letter of what we are told in SHFN 30.

A Yes.

Q Thank you. But, again, just so I am understanding your evidence, you do not know what you do not know, so these discussions are going on. You know about them at a very high level, but no one within the project team is raising with you saying, "It is absolutely key that we have Infection Prevention and Control input into this part of the project."

A No one raised that issue with me, no.

Q If they had raised that type of issue with you, if they had said, "Professor McMahon, I think people are talking at cross-purposes here. We think the specification means A; the contractor thinks it means B. We're going to have a set of discussions to see if we can agree some form of compromise," is that something that you would think there should be some form of Infection Prevention and Control input into? Albeit I am not suggesting you go along – it might be an IPCN or another IPC professional – but is that the type of discussion that Infection Prevention and Control should be involved in?

A Yeah, I mean, if that issue was raised to me in the way that you've described it, I would probably have looked to Lindsay Guthrie and Donald Inverarity to give me the advice about who was best placed to deal with that discussion and provide the input into the process, because I am not a technical expert in that field. They are, so I would look to them to seek advice. If I was required to intervene to, say, chair a meeting, then that's a role I could potentially have played.

Q Thank you. Dr Inverarity, in his evidence, said the only way that he found out that there was an agreement to accept the building, effectively for the building to be handed over, was in an all-staff email that came around. Is that your understanding of how Dr Inverarity found out about the Settlement Agreement?

A I'm assuming so, yeah.

Q And he said that at the point that he found out that Settlement Agreement has taken place, the building has been handed over to NHS Lothian and the Stage 4 HAI-SCRIBE has not been done, he is quite concerned about that, and he raised his concerns with you. Again, is that your recollection?

A He raised his concerns in March of 2019.

Q Yes, so if we just look, perhaps-- Today is not a memory test for you, Professor McMahon, so if we look to bundle 5, page 44. Bundle 5, page 44. You see that there is an email from Ronnie Henderson to Donald Inverarity on 21 March 2019, copying in a range of people, including yourself. It begins:

> "Hi Donald, it was good to meet you yesterday and have the opportunity to reassure and clarify how the project team are addressing concerns raised by IPC."
>
> Do you see that?

A Yes.

Q Then he summarises, effectively, a meeting that has taken place. You will see at point 1 he sets out the attendees, which include yourself, then at point 2 he introduces matters, and at the second bullet point he records that:

> "DI expressed concern that this HAI-SCRIBE audit had not taken place before handover".
>
> Do you see that?

A Yes.

Q Again, I appreciate it is a long time ago, but do you recall that meeting on 20 March 2019 and what was being discussed?

A Actually, it was part of a physical walk around the building which I actually asked for. So I accompanied Donald, Lindsay and Sarah Jane with the others to do the physical inspection.

Q Okay. And we see at point 4, just towards the bottom of page 44, it says on ventilation:

> "RH explained the commissioning and validation that had taken place for both isolation rooms and theatres and that records were available on the project data storage system.
>
> The group visited an isolation room, the theatre suite and a ventilation plant room where RH and DG explained the ventilation philosophy for each.
>
> The group visited external areas to view pest prevention measures and active measures to prevent ingress if pigeon droppings were demonstrated. RH explained that both isolation and theatre validation would be redone once construction works were completed."
>
> Do you see that?

A Mm-hmm.

Q So, in terms of the discussions from the project team, from Mr Henderson and some of his colleagues, at this point in time did

they think what they had done was effectively sufficient? Albeit the Stage 4 HAI-SCRIBE had not been formally done, had not been formally ticked off, but from their perspective did they think there had been sufficient commissioning and validation?

A I think at this point in the process, Ronnie and others responded, I think, quickly and appropriately to the concerns that were being raised by Donald and then through me to the project team. I think the physical visit to the site helped us-- because none of us had been on the site before, helped us to understand that it was still physically a building in construction and that, obviously, once that work was complete, the process could then around the SCRIBE be complete. It wasn't ideal, given that we'd accepted the building in February, that we were doing it in that order.

Q And the way Dr Inverarity described matters to the Inquiry is NHS Lothian have accepted the building, but they have accepted it in circumstances where they do not actually know that that building is safe for patient occupation. Is that what the inquiry should understand?

A We, or NHS Lothian at the time, accepted it in a commercial

and financial basis, but the process hadn't been complete.

Q Yes. So, again, just so I am understanding matters, NHS Lothian accept the building, not knowing whether it is safe for patients to occupy it.

A I guess you would have to say that, given the work hadn't been complete.

Q Thank you. If I could ask you to look on, please, to bundle 6, to page 6. This is a set of email exchanges. We are now in May of 2019. So in terms of the planned opening, we are now really just a matter of weeks away from the planned opening date for the hospital. If we look at the top email, that is an email from Dr Inverarity on 10 May to Ian Laurenson and a range of other people. You see that he says in that email:

> "For information. I'm keen that you are aware of this as I don't think I solely represent NHS Lothian with regards to the potential 'risk' associated with this situation."

Do you see that?

A Yeah.

Q And then we see an email chain sitting below that, an email from Donald Inverarity on 10 May to

Ronnie Henderson, which you are copied into. Do you see that?

A Yes.

Q And Dr Inverarity says:

"Hi Ronnie,

The Multiplex document doesn't indicate what size the theatres are, what the air pressures are in the theatre areas (anesthetic room, prep area, theatre, etc.) or what number of air changes per hour are achieved and neither does it mention what, if any, microbiological assessment of air quality has been performed (that box is blank so I'm presuming none has been performed). Although you're being assured it 'conforms' it isn't explicitly stated what standard it 'conforms' to – presumably SHTM 03-01?"

Do you see that?

A Yes.

Q So, concerns being raised by Dr Inverarity. If we then skip the bold text, you will see that Dr Inverarity quotes a statement, and he says the statement:

"…might be factually correct but there is nothing to back it up and it tells us absolutely nothing about how the theatre performs at baseline. It is essentially asking us to taking everything on trust that it's all okay".

Do you see that?

A Yeah.

Q Again, what was your understanding of how concerned Dr Inverarity is at this point in time, 10 May?

A So, I think he's obviously stated his anxiety that he couldn't give any opinion or confirm anything based on the information, or lack of information, that he had available to him at that point.

Q And if we look, still within that same paragraph, three lines up from the bottom, you see there is a sentence beginning, "But in my role as infection control doctor…" Do you see that?

A Sorry, which----

Q So we are in-- It is still the first main paragraph, and three lines up from the bottom, you will see that there is-- saying, "But in my role as infection…"

A Yes.

Q Dr Inverarity continues:

"But in my role as infection control doctor I shouldn't need to go to source documents and extract that information to interrogate and interpret it myself, it should be clearly and explicitly

included in the validation report."

Do you see that?

A Yeah.

Q So, again, Dr Inverarity's evidence was that, really, he is not an engineer, so he cannot say what the technical engineering parameters are, and what he was expecting to get was a very short, concise report that said there was compliance with SHTM 03-01 and all that would be required from the system was ongoing maintenance, and he did not have that. Is that, again, the type of concern he is expressing to you in May?

A Yes.

Q And then if we just look to the paragraph right at the bottom of the page beginning, "Personally I don't think …." Dr Inverarity says:

"Personally I don't think we're being provided with a 'full report' detailing the validation findings and there is not enough detail for me to know if the theatre is fit for purpose and will only require routine maintenance in order to remain so for its projected life."

And if we look over the page onto page 7, he says:

"I'm happy to be overruled, but for me, I'm not assured by this checklist that theatre 30 is fit for purpose, because the information I would be looking for to allow me to have that assurance is not provided and not accessible by me."

Do you see that?

A Yeah.

Q So, again, just to try and understand, from the project team's perspective, did they think that the commissioning and validation data that they had was enough at this point in time?

A I can't say whether that's true or not because I didn't have lots of conversations with them directly myself. You know, I'm obviously reading it through the email correspondence that Donald has provided and copied me into. Certainly, I think he's right to raise the concerns that he did, that he wanted the actual validated material provided to him, and I think his point about not having to wade through lots of data was a relevant one from his perspective.

Q Because, again, if you just simply look at the documentation in isolation, it does perhaps look like on the project team side, they had had certain assurances, certain documentation provided by the project company and their contractors, which

they seemed quite happy with. Dr Inverarity looked at it and from his perspective, he sort of dug his heels in and said, “No, I want a clear, crisp, independent validation report,” and, again, as I understand Dr Inverarity’s position, he seemed to think if he had not dug his heels in that the hospital might just have opened without the independent testing being done. What is your understanding?

A So, I think he was right to take the approach that he did and I think he was right to raise issues with me that he did, and we took a collective action in some areas; one of those being the fact that we physically asked to go and see the site, for example, just to understand the work that was being done. At the same time, you know, I could see from both sides, project team and from Donald’s perspective, that they were in a process that didn’t necessarily meet anyone’s requirements at that point, because being a building site and not having the ability to do the actual work to validate because it had to be a clean site was causing some tension in the system.

Q We see there, Dr Inverarity says, “I’m happy to be overruled.” Were there discussions going on that simply Stage 4 HAI-SCRIBE just would not be completed before the hospital opened for patients?

A No, and actually I think if memory serves me right, the deputy chief executive was writing to IHSL at the time as well saying, “There’s a number of things still waiting to be done,” and one of those was the HAI-SCRIBE. So, again there was attempts being made to try and move things on as quickly as we could but, ultimately, the HAI-SCRIBE couldn’t be complete until the building was empty, or almost empty in order for us to do it in a way that would truly validate the results.

Q Again, please help me. Albeit the sequencing is not right, the Stage 4 SCRIBE should be taking place before the building is handed over, was it NHS Lothian’s intention that it would always be the case that the Stage 4 HAI-SCRIBE would be completed before any patients entered the building?

A Absolutely. There was never any discussion with me about not doing that.

Q Again, just so the Inquiry understands matters, albeit the Stage 4 HAI-SCRIBE takes place late in the day, should the Inquiry understand that, fundamentally, the HAI-SCRIBE

procedure did its job, that the hospital did not open because there was not a guarantee over patient safety?

A Yeah. I think if you look at the sequence of events particularly in the week running up to 28 June, you know, when things became much more apparent, individuals stepped in and obviously started to take appropriate actions because, ultimately, everyone wanted to make sure that the place was safe to be occupied.

Q Thank you. Again, you will be aware that the next stage in the chronology is IOM Limited come in, they do testing, and they say on their interpretation of published guidance, SHTM 03-01, they do not think that certain aspects of the ventilation system in Critical Care comply with published guidance. Is that your understanding?

A Yeah, they were commissioned to do that independent validation.

Q Again, we will come on and look at things in a bit more detail, but the Inquiry has heard evidence from Dr Inverarity in particular that there is a period where there are internal discussions on the part of NHS Lothian. Those issues are escalated to Scottish Government, but there comes a point in time where, effectively, there is a direction from the Scottish Government that the ventilation system must comply with published guidance, SHTM 03-01, before the building opens. Is that your understanding of what happens if the Scottish Government say, "It has just got to comply with the published guidance before it opens"?

A I wasn't around for parts of that week but, certainly, my understanding was that on 4 July, that was a communication that came from Scottish Government, from the director general through the Cabinet Secretary, that the decision was then taken that we had to comply fully with the standards, and therefore the decision was to move no services into the new site.

Q Thank you. So, there has to be full compliance. Dr Inverarity gave evidence, and his evidence was that there is quite a difficult discussion that is taking place in the early periods, whereby you have a ventilation system that does not comply with published guidance – it is just guidance, it is not a hard-edged legal standard, it is guidance – and if you have departed from that, so you have say four air changes rather than ten, is that safe or unsafe? It is not as safe as ten, but

does it mean that it is unsafe? Are you aware of whether that question, "Was what was built unsafe?", was that question ever answered, or did it become irrelevant because the Scottish Government had simply said, "You must comply with the guidance"?

A So, certainly, there was attempts made, I think, the Tuesday and the Wednesday of that week – so 2 and 3 July – to look at what options there were in relation to moving into the building, and there was four options put forward; one being to not move at all, the other being to partially move in, to decant and do things in situ, as it were. However, the decision made at the end of the day was to not move in, and that was based on the Cabinet Secretary's decision.

Q Then did any discussions about whether what was built was safe or unsafe almost became irrelevant because the decision has been taken, it must comply with guidance?

A It became irrelevant to a point because the decision was then made to establish the Oversight Board and to commission Health Facilities, Health Protection Scotland, and others to look at the evidence in relation to the standards and to ensure that, when we were ready to move in, we met those standards.

Q Thank you. The reason I raise that is if I could just ask you to look at the report that is issued by IOM Limited, there is a range of those reports but if we just look at one example, bundle 6, page 202. So bundle 6, page 202, there is a ventilation validation report and it is just for one particular space; it is the HDU Single Bed Cubicle B1.037. Do you see that?

A Yes.

Q If I could ask you to look on, please, to page 205. There is an executive summary which says:

> "SHTM 03-01 requires that critical ventilation systems are verified against design/SHTM standards and that any inability to achieve the recommended standards is classed as a failure. It is not in the remit of a validation/verification company to state whether an HDU suite is fit for use. Rather, this is a judgment for the client and/or clinical department to make, given their knowledge of the particular clinical procedures to be carried out."

Do you see that?

A Yes.

Q So, again, was your understanding, effectively, all the IOM

come in and do is say, “On our interpretation of the guidance, there is a non-compliance with the guidance,” but they were not offering an opinion individually as to whether the spaces were safe or unsafe, or fit or unfit for the purposes NHS Lothian had for those spaces?

A So, I wasn’t involved in the commission of IOM but, from memory, what they came back with was a statement that said, “It doesn’t meet the required standards,” and that was a statement of fact.

Q Thank you. Around about the time that all of this is taking place, were you involved in any discussions involving potential emerging problems at the Queen Elizabeth University Hospital in Glasgow?

A Not directly, no. The only interaction-- So, the previous chief nursing officer for Scotland, Professor Fiona McQueen, earlier that year had facilitated an opportunity for HEI exec leads to meet to discuss experiences. So, for example, my participation in that was to talk about the experience that we were having around DCN and pseudomonas, and an issue at the Royal Infirmary at the time, and Jennifer Armstrong, who was the medical director in Glasgow, and

the lead, spoke about some of the aspects of the Queen Elizabeth, but, other than that, there was no direct interaction.

Q Okay. If I could just ask you to look, please, to an email, bundle 13, volume 8, at page 2226, please. It is the email towards the bottom of the page. It is from Donald Inverarity to Alex McMahon, Tracey Gillies and others. Do you see that?

A Yes.

Q It is an email dated 5 July 2019 and it begins by saying:

> “Dear all, please see the reply I received this morning from my equivalent, Dr Teresa Inkster.”

Do you see that?

A Yes.

Q Then you will see that really, what follows then is a cut and paste from another email, and if we look to the text of that email, just the final paragraph, it states:

> “As part of the investigation we asked for an external review of the ventilation system. What we found was air changes of < 3 (due to chilled beams), rooms at slightly negative pressure to corridor, thermal wheel technology and ductwork configuration issues.”

Then if we look over the page, page 2227, the email continues:

> "All of this combined was felt to be a factor in these outbreaks as mixing of dirty and clean air was occurring. HPS were asked to investigate, and the conclusion of their report was that our outbreaks were not due to practice or IPC issues, but to the environment. Difficult to prove that retrospectively but it makes sense."

Do you see that?

A Yes.

Q Having looked at that, do you remember considering that email in the period of early July?

A I can remember the email, yes.

Q Again, I would just be interested in any observations you have. Are the emerging issues at the Queen Elizabeth University Hospital, including this email from Dr Inkster which suggests really the problem-- some of the problems they were having, she was attributing to the built entire and ventilation system. Is that something that is significant in terms of your own thought process for the Royal Hospital for Children & Young People and the Department of Clinical Neurosciences?

A I suppose at that stage, given it was 5 July and the decision had been made not to progress in terms of moving into the building, we were continuing to consider all of the options that were going to be available to us from that point of view. So information like this from Dr Inkster was helpful in regards to issues that they had discovered and the actions that they were taking. So it would inform, I'm going to assume, some of the discussions, some of the project and some of the more technical and specialist advisers might have around any tests that we might want to do, but, at the same time, the Cabinet Secretary did commission others to look at the evidence base themselves.

Q In terms of the evidence base, I accept you are not an expert but you are someone that is involved in the process. In terms of what is being reported to you, take air changes per hour, was there clear, robust, scientific data that backed up the air changes set out within SHTM 03-01, for example?

A I mean, evidence keeps changing all the time, but, I guess at that stage, that was the current guidance based on the evidence that was available at that point in time.

Q Because if I just ask you

to look at a minute of a meeting, please, bundle 7, volume 1, page 342. Bundle 7, volume 1, page 342. This is a minute of a meeting that's headed up "Commissioning/Ventilation," taking place on 15 July 2019. Do you see that?

A Yes.

Q A range of individuals attend that meeting including, you will see, yourself just in the third last-- in the last line there.

A Yes.

Q If we look onto page 343, you see that there is a discussion recorded around about critical care design. If we look over the page onto page 344, if we look to the paragraph in the middle of the page beginning "Tim Davison." Do you see that?

A Yes.

Q If we look approximately four lines down, you will see that there is a sentence beginning, "HFS were still considering." Do you see that?

A Yes.

Q The minute records:

> "HFS were still considering their position and how they could make a pronouncement in respect of whether the facility was safe for occupation or not. Lindsay Guthrie provided an update on discussions with UK experts in ventilation. This discussion had focused on the science around the determination of the number of air changes required per hour with it being noted that, as previously discussed, these decisions were not scientifically based. A discussion was held in respect of pressure cascades and air flows in terms of providing a comfortable environment as well as the control of infection.
>
> In conclusion it was agreed that the specification of 4-6 air changes per hour was an arbitrary number. Other aspects had to be considered like the requirements in respect of protecting staff where the statutory position was 3 air changes per hour. It was noted that the Roodlands Endoscopy Unit operated on a 15 air changes per hour. Iain Graham advised that work was underway to check the regime that was in place and there would be a need to come back on this." Do you see that?

A Yes.

Q So, again, having looked at that, does that refresh your memory in terms of the discussions that are

taking place in terms of the underlying signs for air changes in particular?

A Yes, and we had many debates through the course of the Oversight Board in relation to evidence, both scientific and professional opinion.

Q So, again, so the Inquiry understands, you are at this particular meeting, but also at meetings of the Oversight Board, there is a discussion taking place in relation to, "We have this guidance, it says it's best practice, but we can't simply open a hospital on the basis of 'because the guidance says so.' What's the underlying scientific underpinning?" And the discussions are saying, "Well, it's obviously a consensus view, but it's hard to pin down a specific report or a specific study that says, 'This is why 10 is the magic number'"?

A Yes.

Q Thank you. The decision is obviously taken not to open the hospital on the 4 July, and you tell us within your statement you think that was the right decision. Can you just explain in your own words, why was it the right decision for the Cabinet Secretary to take on 4 July?

A Well, I mean, ultimately it was a decision that she took based on information that was available to her,

both from us within NHS Lothian and from our own internal advisors as well. I'd be speculating, but also given the Queen Elizabeth issue, I think err on the side of caution at that point and to seek assurance that all of the hospital actually met the specifications that were required.

Q Thank you. In terms of what happens next, you tell us within the statement that a body called the Executive Steering Group is set up. Can you just explain in your own words, what is the Executive Steering Group, why is it set up, what is it doing?

A So, initially, it'd been set up as an incident management team, which you would normally do with a critical incident, and this, obviously, was in that kind of space. We very quickly, I think within a week or two, changed that to the terminology of an executive steering group. So it did involve, I think, all of the executives of the Board, so chief exec, finance director, medical director, myself and others, but it also included people like Lindsay and Donald, for example, and that was our opportunity as an executive team to ensure that we were progressing all the actions outwith the Oversight Board's meetings, to ensure that the information that we could give

back to them was being done in relation to any actions that were being taken, that were a responsibility for us within NHS Lothian to take action against. So-- And, at the same time, it really helped us to ensure that the current sites were being maintained safely as well.

Q So that is the Executive Steering Group. We have also heard that there's a body called the Oversight Board that is created. What is the Oversight Board and what is it doing?

A So, that was set up by the Cabinet Secretary. She commissioned that. It was initially chaired by Christine McLaughlin, who's the director of finance within the Scottish Government and then Professor McQueen took on the chair of it. Cabinet Secretary was basically looking for a process to be put in place that would provide the opportunity for the evidence to come back to her, that would give reassurance that-- The collective view was that the actions being taken met the specifications and the standards that would allow us to open the building safely. So that group, that board, acted as the, kind of, forum that brought people with expertise or operational responsibility together. It looked at the actions being

taken, the evidence being provided. It signed off actions and it provided advice to the Cabinet Secretary about next steps.

Q So, the Oversight Board is in place effectively as a link, so that information can be fed back to the Cabinet Secretary, who would be the ultimate decision-maker in relation to when the hospital does or does not open?

A Yes,

Q Thank you. If I just ask you to look at the terms of reference for the Oversight Board, they're within bundle 7, volume 2, page 352, and if we could look on to page 354. So, in terms of the background, you see it recorded that:

> "Following the decision to halt the planned move to the new hospital facilities on 9 July, an Oversight Board was being established to provide advice to ministers on the readiness of the facility to open and on the migration of services to the new facility."

Do you see that?

A Yep.

Q So, essentially, what you have told us today. If we then just look to the bottom, you will see there the box 3, which sets out the scope of the

work that is going to be undertaken by the Oversight Board.

A Yes.

Q So the first one is obviously advice on occupation. If we just ask you to look to the final bullet point there. It says one of the tasks of the Oversight Board is identification of areas that could be done differently in the future. Do you see that?

A Yes.

Q Obviously, this is what the Oversight Board is asked to do at the very start whenever it takes place. There is certain other events that take place later on, the centre of excellence that is established, public inquiries set up, for example. Can you recollect whether as a body, the Oversight Board, there was any identification of areas that could be done differently that were captured, or simply did that not happen because of centre for excellence and the establishment of the public inquiry?

A I don't think it didn't happen because of those two things. What happened was COVID. COVID took over everything. So, from that point of view, all of our attention was then focused on both moving those elements into the new site, managing that effectively, whilst also dealing with the pandemic. What I would say is

that the learning is now being implemented. So it hasn't been lost.

Q And how was that learning captured then? You say, for understandable reasoning, there is a pandemic that hits, the priority is to open the hospital and to deal with the pandemic, but the Oversight Board has obviously been set up. It has a lot of experience in terms of managing out a difficult issue on a hospital project. How were those learnings captured, or how will they be captured?

A So, one of them was obviously in the establishment of NHS Scotland Assure and its function. Also, in relation to the work of a function called ARHAI, which is the Antimicrobial Healthcare Associated Infection function which, again, has a lot of expertise in management of outbreaks and infection control, for example, but what I would also say is that, within my directorate, specifically within Scottish Government, a lot of the work that we are now focusing in on is in relation to the job specifications for people who work in this world, the training requirements.

Training requirements also of executives and senior managers, in relation to new buildings and projects and expectations around those as well. Deep-looking at things like career

frameworks and opportunities for people who work in infection prevention and control, but I guess at a more basic level, the point is also that none of this can be done in isolation. This requires an effective team effort, and by that I also mean your contractors, who I wouldn't necessarily have any control over, but certainly in the public sector trying to provide as much support as we can to ensure there's capacity and expertise in the system.

Q Thank you. If I could just ask you to look at a few of the minutes of the Oversight Board. Obviously, the Oversight Board is set up and it is just to try and understand it at key stages, what the Oversight Board is doing. So, if we look to bundle 3, please, page 43. So bundle 3, page 43, which is a minute of the Oversight Board from the 8 August 2019. Do you see that?

A Yes.

Q So, bundle 3, page 43, and then if we look over the page onto page 44, you see that point 2 is ventilation solutions:

> "2.1, Mr Graham presented the previously circulated paper regarding ventilation in the critical care area. Members agreed in principle that if a technical solution was designed that would allow 10 air changes per hour in the required rooms in the critical care area, which complied with the relevant SHTM standard and was properly implemented, then the critical care area would be fit for use."

Do you see that?

A Yes.

Q So, again, presumably a lot of discussion about what does the critical care system-- what does the ventilation system in the critical care area need to do to make sure that it is fit for purpose, and then we see a formal recording of the decision that, if it complies with the published guidance, 10 air changes per hour positive pressure, it is going to be fit for use. If we could look on, please, still within bundle 3, to page 142. You see there is a minute again of the Oversight Board, this time from 29 August 2019. Do you see that?

A Yes.

Q If we look on to page 144, please, you see that there is a discussion at 1.6 of ventilation-specific points.

A Yes.

Q So, point 1:

> "Literature review now complete, demonstrated limited

and sub-optimal evidence around air changes and clinical outcomes. Most evidence had been expert opinion, modelling and outbreak reports."

Do you see that?

A Yes.

Q So, the decisions taken were going to comply with the published guidance, but it seems like there is still discussions ongoing about what is the scientific underpinning and foundations for that. Can you just try and explain what was being discussed, not specifically at this meeting, but just in general about the science around about the ventilation system?

A I think, from memory, people were trying to make sure that we had a robust process in place that allowed us to understand both the published evidence, but also other scientific opinion in relation to-- I mean, given that this is a specialist field from that point of view, and at points there was potential, I guess, for difference of opinion, so we were working through all of those elements.

Q And if we look to point 4, it says:

"Air changes is not a specific hurdle to get over but is the level generally found to be suitable in the majority of developed countries."

Do you see that?

A Yes.

Q So, again, is that your understanding from the literature review that there has been studies, there has been modeling, there is no specific magic to the number 10, but that really is an agreed consensus in the developed world, that that is what you should be doing within Critical Care Units?

A From what I understand of it, not being an expert, yes.

Q And then if we look to point 6, it says:

"Air changes are covered by guidance, not standards. Guidance states air changes can be a combination of mechanical and naturally ventilated, but there has to be an element of control about it."

And then, point 7:

"NHSL did not make a decision to move to four air changes per hour. Six air changes by multi-modes was accepted at the point of the settlement agreement."

Do you see that?

A Yes.

Q I would really just be interested in your view. So, you are

someone who is sitting on the Oversight Board. You are obviously doing your best, with a range of colleagues, to provide advice and assistance to the Scottish Government in terms of what is and is not safe, and you are dealing with a document that is fundamentally called "guidance". So we are not talking about something that is a hard-edged legal standard, "You simply must comply with this in all circumstances," and because of that you do not have the comfort of simply saying, "Here is a legal standard that the government has told us we must comply with." You are dealing with this less clear, slightly amorphous concept of "guidance." Do you think that was problematic? Would it be better if we did not have guidance, but for areas like critical care you actually just did have a hard-edged legal standard that a health board knew they had to comply with for new build facilities?

A It's often a debate on many areas about guidance and standards and whether or not they're enforceable, or not. I think it needs to be contextualized though, in relation to what patient group-- what the function is and which patient group is in that particular area, and indeed for staffing as well because you can achieve, you

know, different air changes with mechanical-- natural ventilation, as it's said there, but, again, that may then mean that you can't have as many beds, for example, in a space that you maybe had commissioned it for, and that might have had an impact on our ability to deliver services. So it's multifactorial, but I think the point in relation to guidance is it's there, but there's other factors that you might want to bring into play in relation to your final decision.

Q And, again, just thinking back to the time you were on the Oversight Board. There is this guidance which says, "If you comply with it, you're complying with generally accepted standards." As someone who was involved in the process of thinking about the potential for departure, and for those of us that have not ever had to make that, how difficult an analysis is it that has to be taken in terms of, "This is the guidance. If we depart from that, is the building going to be safe?"

A Well, I think it was quite clear that we had to achieve 10 air changes. That was the requirement from the Cabinet Secretary.

Q Thank you. If I could ask you to look on please, bundle 3, page 531----

THE CHAIR: Sorry, entirely my fault. Could I just have your answer again? It is simply I did not note it. Mr MacGregor said, "How difficult is it to make the decision to depart from guidance?"

A In this regard, the decision was that we had to achieve 10. So there was no ambiguity around that. So there was no decision about, it's 4 or 6.

Q Thank you.

MR MACGREGOR: If I could ask you to look on bundle 3, page 531, which should be an Oversight Board minute from 5 December 2019. Do you see that?

A Yes.

Q And then if we-- you see at the bottom there is the bold heading, "Commercial Arrangements Paper to NHS Lothian Private Board 4 December 2019." Do you see that?

A Yes.

Q The Inquiry has heard evidence that, really, this discussion is taking place in the context of what ultimately became Settlement Agreement 2 or High Value Change Notice 107. So that is, effectively, you have on the one side the technical side which is, "We are going to comply with the guidance," but you then also have the commercial side to deal with, and albeit that is not your expertise on the Oversight Board, you are involved in discussions that are taking place in relation to that. If we could look over the page onto page 532, the first bullet point beginning "The NHSL Board." Do you see that?

A Yes.

Q It says:

"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 to the proposal. The NHSL Board had requested Oversight Board approval of the decision which they were agreeing to as it was appreciated that the NHSL Board would be signing the public sector up to unknown financial risks, and currently no programme certainty associated with progressing 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 Again, can you just tell me, what is your recollection of the discussions that are taking place in relation to this issue?

A From memory-- I'm struggling slightly, but, from memory, the Board, NHS Lothian Board was actually in a position where it was committing to a significant spend that it was not guaranteed that it would have in order to cover the costs. So from that perspective, it was seeking assurance from the Oversight Board and government that they would assist.

Q Making sure the Oversight Board know and also asking the Oversight Board to make sure that these issues are known by the Cabinet Secretary?

A Yes.

Q Thank you. If I could ask you to look on, still within bundle 3, to page 928, which is a minute of the Oversight Board from 23 April 2020. Do you see that?

A Yes.

Q And if I could ask you to look on to page 930, please, to paragraph 5.2, which is headed "HVC107 Design sign off." Do you see that?

A Yes.

Q Which states:

"The Oversight Board accepted the assurance from Mott MacDonald (Technical Advisors), Health Facilities Scotland (for NSS), and the Authorising Engineer that the specification for air handling units meets NHS Lothian's requirements for critical care and haematology-oncology. The Oversight Board agreed to approve sign off of the specification to allow IHSL and Imtech to procure the Air Handling Units."

Do you see that?

A Yes.

Q So, again, presumably this is the ongoing discussions that are taking place in terms of drawing in lots of different stakeholders, and the Oversight Board discharging its functions in terms of making sure that the design for the hospital fully complies with the published guidance.

A Yes.

Q We see that process continuing if we just look to bundle 3, page 1082, which is an Oversight Board minute from 14 January 2021. Do you see that?

A Yes.

Q And then if we look on to

page 1084, see the heading, "6.1 Technical Assurance," and the minute records:

> "Noted that the Oversight Board on 19 November 2020 had discussed the HFS role in the completion of commissioning and testing process. Confirmed that HFS had been involved throughout the process and once the IOM report was available later this month, HFS would only get involved if there was anything substantive identified as an issue."

Do you see that?

A Yes.

Q So, again, should the Inquiry understand that the Oversight Board is effectively checking that HFS has been fully involved in overseeing the solution that is put in place for the new hospital?

A Yes.

Q Then if we could look on bundle 3, page 1095, which is an Oversight Board minute from 25 February 2021. Do you see that?

A Yes.

Q And if we could look on to page 1097 and pick matters up at the final two bullet points on the page, you see that those record:

> "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. To delay the final service moves further when no issues relating to the ventilation piece had been identified would be very risk averse."

Do you see that?

A Yes.

Q So, obviously, we see at the very start of the Oversight Board, it is set up, it is to make sure that there is full compliance with guidance. We see that there are discussions around about the science and the underpinning of the guidance. We see that HFS are involved, technical advisors are involved, NHS NSS are involved, and we now see Mary Morgan saying that, in her view, the new hospital was now one of the safest and best buildings in the whole of Scotland. Is that a view that you share?

A I think we collectively shared that view.

Q In terms of-- By the time the Oversight Board completed its task and was effectively disbanded, did you have any concerns about the safety of the new building, the Royal Hospital for Children & Young People and the Department of Clinical Neurosciences?

A Given the process that we had gone through and the rigour and scrutiny, and indeed the number of important players that were playing into the process and I think this statement sums it up, that we were content that the building was as safe as any could be and, therefore, we were safe to move people into it.

Q Thank you. So, just in terms of the move, the Inquiry has heard evidence from a range of clinicians who have said the old Royal Hospital for Children at Sciennes, Victorian building, suboptimal for providing treatment, no mechanical ventilation, but equally no suggestion that that building was in any way unsafe. Was that your understanding as the lead for infection prevention and control?

A Yes, at that point. I mean, it wasn't ideal, but it was safe at that point in time.

Q What about the

Department for Clinical Neurosciences? So the decision is made, "We cannot move." Was the Department for Clinical Neurosciences in the same position? Was it a completely safe building?

A No.

Q Can you just explain to the Inquiry, what were some of the difficulties that were being experienced at the Department for Clinical Neurosciences, really in the period up to July 2019 and then in the period until the new hospital ultimately opens?

A Well, I think as you heard from Donald Inverarity, the Department of Clinical Neurosciences, unfortunately, to use a word, was riddled with pseudomonas which required constant review by infection prevention control, microbiology and indeed management clinically of patients and indeed managerial oversight. From that regard, I stepped in to chair the incident management meetings that were happening, sometimes more than once a week, to ensure that the environment was as safe as it could be at that point in time.

Q In your role, how concerned were you about the safety of the Department of Clinical Neurosciences at this point in time,

2019?

A Significantly. We obviously made sure that the Board were aware, the NHS Lothian Board was aware of the risks from that point of view, and obviously Scottish Government were aware of those risks too. The Cabinet Secretary did go and visit the department herself after the decision was made not to move, and indeed I took Fiona McQueen, the CNO at the time, on a visit just to let them actually physically see the environment that people were working within and care was being delivered within.

Q So, children's hospital, not ideal but safe. Department of Clinical Neurosciences, individuals doing their best to manage a very difficult situation but a suboptimal environment for patient treatment.

A Yes.

Q You are obviously not in a decision-making role, you are on the Oversight Board and you are advising the Scottish Government. Why could the Department of Clinical Neurosciences not open earlier than it did?

A I think it could have done. Certainly, elements of it could have moved in, outpatients and some other functions could have moved in,

you know, once we'd done things such as the water testing and we were reassured that that was effective. Others, inpatient services could have moved in as well. So, you know, and I think that was one of the options that had been put forward early in the process, but then the decision that was taken was, particularly in relation to the critical care bit, and the focus was around that, I think, initially.

Q So, again, if you could help the Inquiry, from your perspective, you talked about the difficulties at the old DCN. When do you think patients could have moved over to the new hospital?

A Of course, we were in a position then, because we weren't moving in the timeline that we'd initially thought, that we then became dependent on things like rotas, medical rotas, and every week that you took deciding whether you could or couldn't, obviously would impact on those elements because people were planning weeks, months in advance but, you know, with some planning, potentially it could have happened in months.

Q So, there is obviously the decision in July 2019, "We are not going to open the hospital because we do no know if it is safe", but you think

for the Department of Clinical Neurosciences, it could have opened within a matter of months?

A I mean, my opinion was that we could-- I think we could have done that, but, at the end of the day, the decision was, from the Oversight Board perspective, that we obviously took a lot longer than that to move, and it was into the new year before some of the services moved into the new site.

Q So, your own view is that it could have opened earlier. Was that the collective position of the Oversight Board?

A I can't remember, to be honest with you. I think people would recognise the challenges within it, but I think we were focused initially on the critical care, paediatric critical care element, and that kind of took a lot of the time and energy and focus away from other elements, to be honest.

Q So, your own view is that it could have opened earlier, there may have been some dubiety from others on the Oversight Board. Do you know if that view, that there was at least some individuals, including yourself, within infection prevention and control thought that the Department for Clinical Neurosciences could have opened safely at an earlier juncture

than it did, do you know if that was escalated to Scottish Government and to the Cabinet Secretary?

A From memory, I can't remember, to be honest with you. Obviously, we covered all the elements within the Oversight Board. I can't remember if at any point during certainly 2019 we put a proposition forward again to see if things could move. I think it just then became part of the plan and that plan really didn't kick in, as it were, until 2020.

Q But, again, you say you are not sure exactly what was fed back to Scottish Government and to the Cabinet Secretary. You mentioned earlier in your evidence that the Cabinet Secretary had attended the Department for Clinical Neurosciences. Is that correct?

A She went on a visit after the decision was made not to move into the new building.

Q And, at that time, had she been fully appraised of the difficulties and challenges that you have addressed at the old Department for Clinical Neurosciences?

A I mean, I was certainly making it known through Professor McQueen that those challenges were there, and that's why I certainly invited her to come and visit the DCN with me

and to walk around.

Q Thank you. The final issues that I would like to raise with you, Professor, are really just some reflections in terms of the project and perhaps issues that could potentially be done better in the future, and I think we have covered a number of issues. We have obviously talked through the HAI-SCRIBE procedure and, as I understand your evidence, it was all done late in the day, due process perhaps was not followed but ,fundamentally, the HAI-SCRIBE process worked because the hospital did not open without that procedure being completed. Is that correct?

A Yes.

Q One issue that I would be interested in your views and reflections on, and this is perhaps both in terms of your involvement in the project but also in terms of your position as chief nursing officer, NHS Scotland Assure has been created as a centre for excellence. What are your views on NHS Scotland Assure? Is it going to cure all issues with the built environment in relation to new build hospital projects?

A So, my observation would be that it's only a couple of years old and it's in its infancy. I think it's still finding its way in relation to the ask that's been placed on it. I don't think Assure, singularly, will deliver everything that's required. I think that comes from multiple stakeholders. So there are other functions: for example, NHS Education for Scotland, there's Scottish Government policy input and equally the health boards themselves, because one of the things I think we do need to look at in the medium to longer term is the capacity at all levels and the expertise at all levels to meet the current requirements.

Q And in terms of NHS Scotland Assure itself, are there aspects of what that organisation does that you think could be improved upon?

A I don't think so. I mean, I think there's an interpretation that it's an inspector, it's a regulator, and it's not that, for example, so I think there are some misconceptions around its function. That's a responsibility for others in the system to undertake. I think they need to focus in on providing the expert advice that they can around the built environment, but, again, I think that's very much on a partnership basis because they will need to work with boards because boards still ultimately hold the accountability for any new build or any refurbishment. So it's very much a

relationship issue.

Q Thank you. The former Cabinet Secretary, she will be giving evidence next week. In her witness statement, she says that her aspiration for the centre for excellence is that it would follow a clerk of works model. So there effectively would be someone walking around with a clipboard. As you say, if you look through the documentation for NHS Scotland Assure, it is very clear that it does not have an inspection or a regulatory function. Do you think that is the right model, not to have that inspection or regulatory function?

A Yes, because it would just overcomplicate the landscape. We already have inspections through Healthcare Improvement Scotland, for example, or the Health and Safety Executive, so I think to add another regulator or inspectorate in would just cause confusion in systems and probably duplicate more work and actually take people away from the jobs that they need to do. I think focusing in on elements of providing evidence and expertise is what's required.

Q Thank you. The Inquiry heard evidence from Sarah Jane Sutherland, infection prevention and control nurse, and Lindsay Guthrie,

who also works as an infection prevention and control nurse, and they expressed significant concerns about the demands that are being placed on infection prevention and control professionals, and particularly infection prevention and control nurses, that have been created through the new system of key stage reviews, in particular, through NHS Scotland Assure. Are those concerns that you are aware of in your position as chief nursing officer?

A So, I work very closely with the executive nurse directors across all the boards, and actually from 1 April every executive nurse director will have responsibility for HAI within their remit. So that's a continuity piece which is very important. So there's that professional support in there, but, obviously, in terms of the demands through the review process, IPC is one element of that. Again, like the SCRIBE, it's multifactorial and there are many players that need to play into it. I think what we have at the moment is that the system as it is and the capacity that we have don't meet the demand.

Q And that was an issue that I was going to come on and ask you about. In very simple terms, are there sufficient infection prevention

and control professionals, and particularly infection prevention and control nurses, to carry out the workload that is going to be created by the key stage assurance reviews?

A So, I'm not sure it's just about the key stage review itself. I think it's actually about the requirements of the current facilities that people are in, and any new build, and expectations of the role that IPC will play in those, and that's also crossing to microbiologists as well, for example. I think we're in a process just now, and it goes back to the learning point, of identifying that we don't have the capacity and indeed the skills at the levels required to meet those current demands.

So from that perspective, certainly one of the things that my directorate is taking forward is a job description with key role descriptors within that about, what is it we're expecting of these individuals, particularly in relation to the built environment? How do we create a career framework for those individuals, because it's a very specialist area and progression can be quite limited within that. And, actually, how do we do that in a way that supports them through the education and training that they would be required to undertake as

well? So a lot of those factors are currently being looked at, at the moment.

Q At the minute, are there enough infection prevention and control nurses in Scotland to provide all of the requirements for key stage assurance reviews and the other matters created by NHS Scotland Assure?

A So, I don't think I could answer that question at the moment, because I haven't got any information that tells me in a substantive basis that boards can't meet the requirements. I think what they would probably say is they're stretched in relation to meeting all the demands.

Q So, as chief nursing officer for Scotland, you cannot tell the Inquiry whether there are sufficient infection prevention and control nurses in Scotland to carry out the workload created by NHS Scotland Assure?

A So, we're in the process of undertaking a workforce review – that's part of it – to understand, because what I would say is that, certainly when I was in Lothian, we did significantly invest in that workforce, particularly in the nursing workforce, to create capacity and expertise. I think boards are in different places from that point of view in terms of trying to

recruit into posts. So it's not that they don't have the posts; it's the recruitment into the posts.

Q So, can you explain to the Inquiry, why is a system being put in place without an assessment being made of whether there is sufficient resourcing to carry out everything that has been set up?

A My view would be that the ask to set up Assure was an ask and it was implemented in terms of establishing it. My personal reflection would be that in establishing that, we hadn't understood what demands that would place on the capacity we had at the time, and now we're trying to marry the two up.

Q Thank you. The infection prevention and control nurses that gave evidence to the Inquiry also expressed very significant concerns about what they are being asked to do at a practical level. One of the concerns they expressed was that they feel they are being asked to do work that is outwith their remit and outwith their professional registration as nurses, because the way they described it is to say, "Well, I'm not an engineer, I'm not a plumber, but I'm being asked to be the quality control officer for water systems." Are those difficulties and issues that have been

fed back to you in your capacity as chief nursing officer?

A Yes, and that's why we're taking the work forward. I've referenced in relation to what is a team job description and what is an individual job description, particularly for infection prevention and control nurses, and what would be the core elements of those jobs. So there is no ambiguity or unrealistic expectation placed upon them.

Q Okay. So, job specifications are coming in terms of just exactly what is expected of a nurse, and particularly an IPCN, through the procedure.

A Yes.

Q Thank you. Is there a timeline for when that work is going to be completed?

A Well, I hope to have it done before I demit office at the end of April.

Q Thank you. In her witness statement and in her evidence to the Inquiry, Lindsay Guthrie described that the current system that is in place – really due to the challenges, the difficulties, the lack of capacity within the system – she described it as "setting boards up for failure." What would your observations be on that?

A I don't think I would agree with that observation. I'm sure that's how Lindsay might feel personally, but I don't think anybody has set anything up to fail. I think everything has been done with the best of intention.

Q If I could ask you to have before you, please, bundle 13, volume 7, page 319. So bundle 13, volume 7, page 319. Sorry, bundle 13, volume 7, page 319. So bundle 13, volume 7, page 319. This is not an email that you will have seen before. It is an internal email at NHSL sent by Tracey Gillies, and it is just to pick up the observations that Ms Gillies makes towards the bottom of that email, beginning, "Given that we already have to reduce…" Do you see that?

A Yes.

Q It says:

"Given that we have already have(sic) to reduce HAI scribe(sic) attendance as there are simply not enough nurses in IPC to provide the essential service to clinical areas in the here and now, and not enough IPC nurses in Scotland with the requisite qualifications to do this more technical work, someone will need to feed back to SG capital colleagues that their programme will be undeliverable."

Do you see that?

A Yes.

Q Again, in your position as chief nursing officer, are you aware of these types of views that exist within health boards, that the programmes that are in place are simply undeliverable in the view of health boards?

A I think there's certainly capacity issues. I mean, I think in terms of deliverability, that's a slightly different matter. Obviously, I've not seen the email correspondence here. That's Tracey's view on it from that perspective, and one of the things that we are doing through all the work that I've described with you is we are working with the networks that we have in Scotland that represent infection control nurses and infection control doctors to try and achieve some of those aspects around capacity and skills that are required, but, at this point in time, the system as it is, is very pressured around the current environment and requirements to build new facilities as well.

Q If there is a recognition that there is a capacity issue, has the Scottish Government made more funding available, then, to try to

provide more resource within the system?

A In relation to----

Q Well, in relation to-- You have mentioned a number of times that there are capacity issues, which I think-- my understanding is there are simply not enough people that are working. There are not enough people to try to do all of the tasks. Is that correct?

A Yes. I mean, the responsibility comes to health boards, in terms-- they are the employers, from that point of view. They are undertaking their own workforce assessments, so the need and that perspective.

Q I think the question I was asking though was, if there are these capacity issues that exist within the system, at the Scottish Government level, have more resources, more money been made available so that those capacity issues can be resolved by boards?

A So, certainly through some of the work that my directorate is doing, looking at aspects like training, online materials, the clear framework, the job description, that's an investment of time. It's not money itself directly to the boards, but it's to assist boards in order to manage some

of this. In terms of actually identifying how many individuals the boards think they may require, that's a piece of work through the exec leads within boards and within the boards themselves, but everything that we're doing is trying to assist them in achieving those outcomes.

Q One other issue that the infection prevention and control nurses raised was the issue of training, that they are increasingly being asked to do a lot of work, be involved in meetings in relation to technical systems. So albeit they are looking at it from an infection prevention and control angle, they do not have any mandatory training in the built environment. They are not looking to become engineers, but they do not have any basic mandatory training in relation to the technical aspects of water systems, ventilation systems. Do you think that is a skills gap in relation to the nurses?

A I think going back to the point I was making, about what their core role is and isn't, is important. I think there's been, perhaps, expectation placed on them that they might have expertise in those areas and that isn't the current remit of an IPCN, for example, but there are others in the system, through capital

planning or Estates or Facilities, who have much more expertise, or independent contractors. So, again, going back to processes such as the KSAR or the SCRIBE, this is where it has to be done in partnership. Other people need to play their role in it, and the point that Lindsay, I think, made to you, no one should do anything that compromises a professional regulation. So, from that point of view, I wouldn't expect any nurse to do anything that they were not fit to give advice on.

Q And, again, it is perhaps not asking to give specific advice, but if we just think back to the basic principles set out in SHFN 30, which talks about a partnership approach, my understanding is that the reason for that partnership approach is effectively there are grey areas: where does the work of an engineer end? Where does the work of a clinician begin?

Do you think for IPCNs that are being asked to undertake some work on large, new build hospital projects-- not talking about the refurbishment projects that might be slightly more standard, but taking on a big, brand new, new build hospital, complicated water systems, complicated ventilation systems, do you think, before they are asked to undertake their role as part of

the team, albeit in the IPC function, that they should have some basic, mandatory training in the built environment and those critical systems, particularly water and ventilation?

A I think if we were to build them into the core job description then absolutely, you know, from that point of view. I mean, the current-- from memory, the current master's programme that most would go through to achieve IPCN status doesn't actually address those, so, again, that would be something that would have to be looked at if it was going to become a core function that was expected of them.

Q Okay, thank you. The final question that I would want to ask you is, it is really a general open question, there is probably two parts for it and it is really just to check if there is anything that has not been covered off, either in your statement or your evidence today, in relation to how you think these types of projects could be done better in the future. So part one would really be drawing on your experience working on the project. Do you think there are any aspects we have not covered about how practices could be improved in the future?

A I think my reflection

would actually draw on comments that Lindsay and Donald both made, actually having heard their evidence to you, that process is hugely important, and that following the process is hugely important, but equally it's for all stakeholders to play their role in that process. I think the point that Donald made, and I think he said it like this, that having those people with their clear responsibilities and accountabilities in the same room, hearing the same conversation at every step in the process is hugely important because, actually, things tend to go on outwith the process and therefore people are not always part of the same process. I think we have to be very rigid around the elements of that going forward.

Q Thank you. So, that would be part one, effectively, your reflection from the project team. You have also mentioned today that obviously NHS Scotland Assure is in its relative infancy, still learning as it goes. You have mentioned some things as chief nursing officer that you are working on, things like the job specifications so that there is not any lack of clarity. Apart from the matters we have covered today, is there any ongoing work that you are aware of to try to perhaps improve some of those

processes for future projects?

A Yeah. I mean, obviously, in terms of the work of Assure, NHS Education for Scotland, and ARHAI, which is the Antimicrobial Healthcare Associated Infection function, we're actually reviewing elements of those to see how they work. Do they work effectively or not? Could we change any of those? And, again, that's all part of the learning point, but also a fundamental part of this is, how do we ensure that we use the totality of the capacity and expertise we have within Scotland, within NHS Scotland, to meet the current and future demands? Because it can't, I think, just be met by boards themselves. That's where Assure, NSS, National Services Scotland, NHS Education, and indeed government themselves, have to play a collective role in looking at that.

Q Thank you. Professor McMahon, thank you for answering my questions this morning. I do not have any further questions at this stage. Lord Brodie may have questions, or there may be applications from core participants, but thank you.

THE CHAIR: Thank you, Mr MacGregor. I do not have any further questions at this point, Professor, but I want to take the opportunity to check that no one else in the room wants to

ask a question, either through Mr MacGregor or otherwise. So, could I ask you to return to the witness room, and I would hope that you will be able to come back in 10 or 15 minutes and we can confirm the position.

THE WITNESS: Thank you.

(Short break)

THE CHAIR: Mr MacGregor?

MR MACGREGOR: Lord Brodie, there are just two matters arising, which I am happy to deal with.

THE CHAIR: All right. If we could bring back Professor McMahon. Professor, we have, as I understand it, perhaps a further two questions, which Mr MacGregor will direct to you. Mr MacGregor?

MR MACGREGOR: Thank you. Professor McMahon, the first issue to pick up on was I think in your evidence you mentioned an entity called HIS. Did I pick you up correctly?

A ARHAI?

Q I think you----

A Oh, HIS.

Q HIS, which I understood would stand for----

A For Healthcare Improvement Scotland.

Q Healthcare Improvement Scotland, thank you. It was really just- - I had picked you up as saying that you thought that HIS had a regulatory function.

A So, what HIS does, it goes into hospitals, both announced and unannounced, to do inspections. It's more of an inspectorate-type function in relation to standards, and there's some standards within there that are around infection prevention and control.

Q Thank you. So, perhaps it's going in and doing inspections, but not necessarily a formal regulator as one would have for, for example, the Health and Safety Executive.

A Yes, yes.

Q Thank you. Then the second topic was really just-- We obviously discussed quite a lot today about Settlement Agreement 1 and the fact that Settlement Agreement 1 was approved without the Stage 4 HAI-SCRIBE being formally signed off; that was going to come later. It was really just to try to draw on your experience sitting as a former director of a health board, and to think through that the governance function that the Board itself would be applying. So, you obviously have the project team. Their main driver would simply be to complete the project, but there is going to have to be a decision taken as to

whether the Stage 4 HAI-SCRIBE is completed in line with due process, it is all signed off before the building is accepted. Is that the type of decision that should be made by the project team, or is that something that should really be made at Board level?

A So, historically it was something that was made through the project team. Again, the Board or committees didn't give scrutiny to that level of detail or that part of the process.

Q But if we could just think about the Settlement Agreement, so that is a document that is, for good or ill, going to be changing potentially the contractual arrangement set out in the project documentation. It is going to involve a significant sum of money being spent. Do you think at that stage, for that type of decision, that should be being taken at the Board level as opposed to being simply taken by the project team?

A Obviously, information came to the Board and the Board made a number of decisions, but in relation to SA1, I mean, I wasn't involved in the process around about that but certainly, you know, it was either through the finance and resource committee or the Board itself where the ultimate decisions were

made to progress on those matters.

Q If we are just thinking of progressing, so the hospital is going to be accepted, payments are going to start being made without the Stage 4 HAI-SCRIBE being completed. Do you think that decision being made, that due process is not going to be followed, is that a failure in governance on the part of NHS Lothian?

A I don't think it was at the time because it was new to me too, so, actually, from that point of view, that was subsumed within the project process. It wasn't something that the Board itself was being expected to understand or agree on as part of the process to getting to SA1. I think hindsight and looking back, and perhaps this is part of the learning, and this is some of the work that Assure and others are looking at, what is the role of executives and senior managers in relation to those various points in the process, and making sure that things like the SCRIBE process are built into that. So I would expect, going forward, to see much more rigour from boards in relation to compliance at all levels.

Q So, rightly or wrongly, that issue of the Stage 4 HAI-SCRIBE, that was not on the Board's radar whenever Settlement Agreement 1 is

being signed off.

A Not in the least, yeah.

Q You are saying, again, we are looking back here with the benefit of hindsight, that perhaps is an area that needs to be looked at further, in terms of just exactly what the decision-making should be, and what the governance of that decision-making should be?

A Yes, I think that'd be fair.

Q Okay, thank you. Professor McMahon, I do not have any further questions, but thank you again for answering my questions today.

THE CHAIR: Thank you very much, Professor. You are now free to go but before you go, can I just express my thanks? My thanks for your attendance today, your attendance yesterday, and all the work that will have gone on into preparing your statement. I am very appreciative of that and wish to thank you, but you are now free to go.

THE WITNESS: Thank you very much.

THE CHAIR: Now, as I understand it, Mr McClelland is taking over the remaining witnesses for today.

MR MACGREGOR: Yes, my Lord.

THE CHAIR: I think we might take a 15-minute break to allow people either to have coffee or a second coffee, and we will resume with-- Who-- Which is the first witness you intend to take?

MR MCCLELLAND: It is Professor John Connaghan, my Lord.

THE CHAIR: Professor Connaghan, right. Sit again at about twenty-five to twelve.

(Short break)

THE CHAIR: Now, Professor Connaghan?

MR MCCLELLAND: Yes please, my Lord.

THE CHAIR: Good morning, Professor Connaghan. Now, as you understand, you are about to be asked questions by Mr McClelland, who is sitting opposite you, but, first, I understand you are prepared to take the oath?

THE WITNESS: Yes indeed, my Lord.

Professor John Connaghan
Sworn

THE CHAIR: Thank you very much, Professor. Mr McClelland?

Questioned by Mr McClelland

Q Thank you, my Lord. Could you please confirm your name?

A John Connaghan.

Q And it is the case, I think, that you have provided a witness statement to the Inquiry?

A I have.

Q Could we have on screen, please, the document at witness bundle volume 1, page 215? Do we see there your statement, Professor Connaghan?

A Yes, indeed.

Q Does that statement set out fully and truthfully your evidence on the matters that it addresses?

A It does.

Q Is there anything in it that, in your view, needs to be changed or corrected?

A One minor typographical error under section 3; graduation in 1979 and not 1976.

Q Okay, thank you. Now, you are, I understand, currently the chairman of NHS Lothian. Is that correct?

A I am.

Q And you have held that position since July 2021?

A From 1 August 2021.

Q Prior to that, between March 2020 and July 2021, you were the director general of health and social care in the Scottish Government?

A No. They-- I entered the Scottish Government as chief performance officer and after a while I became the chief executive of the NHS in Scotland during the period of COVID, or partly during the period of COVID.

Q Okay, thank you, and at various earlier stages in your career, you held chief executive posts of a range of NHS trusts in Scotland.

A I did.

Q And from 2016 to 2019, your statement says that you were the director general of the Irish health service?

A I was, and that was based in the Republic of Ireland.

Q Okay, and is that akin to the post that you later held as the chief executive of the NHS in Scotland?

A It's commensurate with that post.

Q To what extent over your career have you been involved in the delivery of major healthcare construction projects?

A I have been involved in the construction of projects as the chief executive, for example, of the Western General, where we-- some--

in the time I was there, started the development of the Anne Ferguson building, as an example. After that, not a lot of direct involvement.

Q And what was the nature of the Anne Ferguson building in terms of scale and technical complexity?

A It really was just a single building on the site. As I recall, the capital scheme at that stage was about £78 million, funded directly by the Exchequer. I would suggest it would probably be twice that in today's prices, to give you an idea of scale.

Q Okay, and has your experience in that and your other roles given you an insight into the challenges that a health board or trust faces when tasked with a major construction project?

A Broadly, yes, I would say.

Q And what would you see the challenges as being?

A The challenges of being a strategic fit with the direction of travel, both nationally and locally. How well does the facility serve the needs of the population? How does it achieve value for money? How does it secure a safe environment for patients and staff? And how will the building or facility be flexible enough in the future to cope with changing demands?

Q The Inquiry has heard evidence from others that this sort of project might be something that those working in health boards may do once, or perhaps not at all, in their whole careers. What do you see as the challenges for health boards in building a team with the knowledge and experience needed to run these projects successfully?

A Well, it depends on the scale of the health board. You've got some very large organizations like Glasgow and Lothian that would be better placed to have a kind of critical mass of in-house expertise. Smaller health boards might not have that level of critical mass and have to seek advice and capability outside. So, it depends. There's quite a difference in terms of size of health boards, as you understand.

Q Okay, and what about the challenges of adding a project of that nature on top of the pre-existing workload of delivering healthcare services?

A I would acknowledge that's a challenge, but every project coming to a health board for approval, and then onwards to the Scottish Government for approval, should be able to assess the requirement for that technical and managerial support

which is needed. That will be built into project costings and built into the workforce and experts' advice requirements for that particular project.

Q Okay, and so would you envisage that sort of thing being built into the business case process at the outset?

A Yes, it would, because we would need to account for those costs.

Q If we turn then to the time period to which your evidence to this Inquiry relates, in around July 2019, you were at that time the chief performance officer in the Scottish Government. Is that correct?

A Yes, indeed.

Q And was that a post in the Health and Social Care Directorate?

A It was. It was a post which was created, which I took up in January 2019 on my return from Ireland. It was essentially a post which was to aid the government's objectives in terms of reducing waiting times and improving performance across the NHS, but also, as I had understood it, as an aid to the potentially new director general that was coming in, in the spring of that year, who was Malcolm Wright, because I had previously done posts like that. There

was an added benefit in me being around but, principally, that was a post to deliver government objectives on performance.

Q Okay, so a focus more on the delivery of healthcare services rather than the delivery of capital projects?

A Absolutely. Capital projects would not have been in my remit for that post.

Q In that role, did you report to Malcolm Wright as well as having that supportive role?

A Indeed, that was my direct line management route.

Q And it appears from the documents that you were involved at the very earliest stages of the Scottish Government's awareness that there might be issues with ventilation in the Critical Care Department at the RHCYP, and one of those is an early briefing that you were copied into on 3 July 2019. So, in terms of our timings, that's the day after the matter came to the attention of the Scottish Government.

If we could have up on screen, please, the document at bundle 7, volume 1, page 48. I should say, my Lord, I don't appear to have the documents coming up on my screen here. I do not know if somebody with

the technical know-how could perhaps arrange for that to be done. I can manage without it but it would be helpful if it was available.

THE CHAIR: Not that I have any technical know-how to contribute, but it is on my screen, and you have it---

UNKNOWN SPEAKER: It is on my screen. I can see it.

MR MCLELLAND: I have raised it so those in the technical-know may be able to deal with it, and I can manage for the time being without it.

THE CHAIR: Right. I am working on the basis that those in the back room know that there is a problem. Right.

MR MCLELLAND: Thank you, My Lord. So, you should see, I hope, in front of you, Professor Connaghan, an email from Alan Morrison to Malcolm Wright, and you are one of the copy recipients. Do you see that?

A Yes, I do.

Q And I am just going to read some of this to put this into context. What Mr Morrison says is, "Malcolm, John, I believe Tim Davison"-- and Mr Davison's the chief executive of NHS Lothian at the time. Correct?

A Correct.

Q

"I believe Tim Davison has phoned you to summarise the outputs from this morning's meeting between HFS, HPS, NHS Lothian and myself, to consider the risks associated with the move of ICU to the new RHCYP. The following issues were raised. [And he says] The main risks we identified were, first of all, the major concerns were raised about the risk of doing the permanent solution with patients in situ [there's a list of other concerns or risks]."

Then paragraph below that:

"There's still a lot of unknown factors, including the safety implications of running the facility with four air changes rather than 10, and the safety of the environment in which the patients are currently occupied, i.e. is the new facility with four air changes an hour still safer than the current site?"

And then just on that page, he finishes up by saying:

"Given the information available, the consensus was that, with unknown risks associated with moving patients and then modifying the ventilation of the building, combined with the

believed safe environment of the current facility, the safety of patients would be better served by delaying the move and modifying the ventilation in the new building before moving patients."

So, do you recall receiving this briefing following the meeting with those various parties?

A Yes, I do.

Q So, we see from that briefing that risks had been identified, certain unknown factors had been identified, but a consensus was already developing about how to respond. Is that fair?

A It is fair. I think this is a very important note. It came in just after midday on 3 July. It preceded a meeting that I had with the-- which I'm sure you might go on to, with the Health Board's senior exec team, but it really confirmed our developing thoughts on what the potential risks would be around that move. There are probably more risks that are not identified on that note, but understand this was early in our thinking of what the potential issues were.

Q Okay, thank you, and then if we move over the page to page 49, Mr Morrison says that, in addition, John, I think that must be you, asked about why this was not identified earlier, and he says that:

"As part of the settlement agreement, NHS Lothian agreed that ventilation for general wards could be four air changes per hour. They should have specified that critical care beds were not part of that derogation, but they didn't. So, the contractor has used this as evidence that only four air changes an hour were required [and so on]."

So, as well as a consensus emerging about how to respond to this, do we see that the nature of the problem, or the source of the problem, was already reasonably clear, at least an outline?

A Yes, that's a reasonable conclusion.

Q Now, one of the unknown factors that Mr Morrison had set out concerned the safety implications of running the facility with four air changes rather than 10, and the issue of whether the new facility with four air changes an hour was still safer than the current site. Now, does that second factor reflect the fact that there was no mechanical ventilation at Sciennes?

A I think it does, but I wouldn't like to give the Inquiry

definitive evidence about that, given my lack of expertise in that particular area, but I think that's a fair reflection when one compares the new facility with the older facility.

Q Fair enough, and as far as you were aware, were patients considered to be safe at Sciennes?

A As far as I'm aware.

Q So, there was clearly uncertainty at this stage about whether it was actually unsafe to have four air changes per hour. Is that fair?

A I think it was, but I think we also need to consider the other factors that are on page 48 of this bundle as well. The most important factors for me in terms of considering the safety or the ability of the site to be moved into new premises are, first of all, the evidence available over the 3 and 4 July could not absolutely guarantee that the move in whole and part would be safe. Secondly, there are issues I'm sure that everyone realises about public confidence, and there I reference the issues that we already knew about in terms of Queen Elizabeth. Thirdly, the risk of knowingly placing patients in an environment where any remedial actions might need to take place in the same building. I don't think we understood the potential risks that

were about that.

A thought process emerging, as you can see over 3 July, about what other issues would be potentially on the site that would yet to be uncovered. Health Facilities Scotland at that time, as I recall, could not immediately carry out any due diligence to answer that question. It would take some time. I think, as we subsequently saw, three or four months would be required, and another one that I was particularly concerned about is-- which I would call split-site working, having one part of the intended move taking place without the other part and the consequent knock-on impact on clinical rotas. So, all of those things, as well as the 4 to 10 changes per hour, were in our thinking.

Q Yes. So, I was focusing on that particular issue, but you fairly explained that there are actually a multitude of other factors which fed into the decision-making at the time?

A Indeed.

Q If you will bear with me just while I return to the question of the four air changes for the moment, and I accept what you say that other considerations were relevant, to what extent, so far as you were aware, was consideration given to whether the

critical care ventilation as originally built, that is the four air changes per hour and balanced pressure, might in fact have been safe for its intended clinical use?

A I don't really think I can answer that with, you know, any definitive statement. I know it was in the background, it was a primary factor in halting the move. As I recall, there was an initial note from Tracey Gillies to Tim Davison on 1st, I think it was, of April, which laid out some of the risks associated with that. I can't recall exactly what was in that note, but it was certainly in our thinking that that was a material factor which would require to be resolved before that move took place.

Q Of course, the guidance in SHTM 03-01 for critical care areas was to have 10 air changes per hour and 10 pascals of positive pressure. To what extent were decisions being made in government on the basis that one had to comply with those parameters in order to ensure safety?

A Well, I think one needs to address that question by looking at why we have Scottish Health Technical Standards. These are drawn up in terms of the-- what was the perceived best practice at the time. So, therefore, it was critical that any

new facility where we required those Scottish Health Technical Memorandums to be observed in terms of the building was actually delivered. Why would we want to accept a building that did not meet current day standards?

Q Now, you describe them there as standards, and this may to some extent be a semantic question, but they were presented in something that was described at the time as "guidance" rather than as a standard which health boards were compelled to meet, but do I take from your answer that decision-making in government at this time was proceeding on the basis that compliance with these parameters had to be done in order to ensure patient safety?

A Absolutely, and you can see that in the original contract intentions from NHS Lothian where they set out to achieve that specification.

Q And was decision-making also based, therefore, on the basis that any departure from those parameters would be ipso facto unsafe?

A I have a difficulty in agreeing to it being unsafe because, I'm sure people can explain this better than me, there are various levels and

degrees of assurance. We would want to have the maximum possible level of assurance built into any environment, and that is I think explained by the fact that we wanted to have buildings in accord with those Scottish Health Technical Memorandums.

Q And, again, just thinking about decision-making at the government level, to what extent, so far as you were aware, was consideration at that level given to the possibility that the ventilation system as originally built might in fact comply with the guidance, depending on how one interpreted it?

A I don't recall any discussions about that. It seems a rather obscure point because the testing from IOM, as far as I understood, came up short in terms of meeting those technical standards, if I can use that term again.

Q Yes. So we had IOM saying quite clearly that the air changes in these rooms didn't meet the requirements of the guidance, but the ventilation designer on the project maintained at the time, and indeed continues to maintain, that the design was compliant with the SHTM guidance, at least in the way that they interpreted it. Was that something which-- Was that a consideration

which did not make it into the government's knowledge?

A I can't answer for what would be in the section of advice that comes to ministers, cabinet secretaries, from colleagues that are perhaps closer to the technical aspects of that. So I think you're asking the wrong person here. If you were to ask somebody like, let's say, Alan Morrison or the engineers that are associated with that, they would be able to give you that but, clearly, from the note that we have just seen from Alan Morrison on that very subject, there was certainly a deep consideration of that particular issue in that note.

Q Okay. Given the cost and disruption likely to be involved in replacing a new ventilation system, do you agree that it would be appropriate to consider whether the system as installed, even if non-compliant with the guidance, might nonetheless have been safe for its intended clinical use?

A That's a possibility. You could certainly do that but, as I've explained earlier, there are a number of different factors that would come into government consideration of whether or not they supported such a move, okay? But it was quite clear in terms of the evidence that was being put forward at that stage, in the very

early days of the 1st, 2nd, 3rd, 4 July and onwards, that the general opinion was certainly solidifying around the fact that we should not move.

Q Should not move?

A Yeah, should not move.

Q Yes. I appreciate that your involvement was limited. You fairly explain in your statement that you were involved in the early stages and then other people took it on, but so far as you were aware at the time that you were involved, were people in the government actively considering whether, despite the non-compliance with guidance, the system might nonetheless have been safe for its intended clinical use?

A I think only in part. There was a time somewhere around about 2 July, as I recall, that while we understood the general advice, and indeed this came from NHS Lothian, was not to move the Sick Children's part of Royal Hospital for Children & Young People, but to consider a partial move which would be DCN. There was certainly, in the very early days or very early hours of our engagement with Lothian and across government, that the potential for a partial move might be possible, okay?

Q Yes.

A But then I think as we

considered further, that became increasingly unviable as a course of action, and indeed the letter of 4 July from the director general to the chief executive of NHS Lothian, at that point in time I think laid out quite clearly where Scottish Government were.

Q Yes, and we will come to that shortly.

A Yes.

Q So just returning to that first day, you say in your statement that towards the end of that day you started to wonder if this issue with the critical care ventilation was the only one that might arise or if there might be more. Can you just expand on that mode of thinking?

A Yes, indeed. My first reaction on hearing this was, "Are we absolutely certain that this was only confined to the critical care air changes issue?" I had a stream of thought in the first day around whether or not we could supply a workaround on this, which was a portable unit that might supply the critical care facility. After consideration, NHS Lothian decided that would not be viable. I think that was probably the right decision in hindsight. So it was an option, but it was never a serious option that was on the table.

However, towards the end of that

and having seen over 3 July that note from Alan Morrison and others, I began to consider in my own mind, "Is this not-- Is this more than just an isolated incident? Are there other issues that need to be rectified and how can we prove that the facility is absolutely up to standard?" So that's the background to that thought process.

Q So, was there a sort of sense of anxiety that there might be other problems, that the discovery of one might suggest that there will be others?

A I would say yes, a little bit of anxiety over the course of 2 and 3 July, which is why government asked for assurance from HFS, HPS, in terms of just making sure that there were no other issues and, as we know, the history of that is that that would take some time.

Q Yes, okay. Was it possible to look at this the other way around, that the Health Board's own processes and procedures had detected the problem and they themselves had disclosed it to the government?

A Yes, that's a fair assessment.

Q And is that perhaps not an indication that whilst, you know,

true, a problem had emerged, the Health Board had demonstrated itself to be capable of detecting them and responding to them appropriately?

A And we would expect that. NHS Lothian had excellent technical and managerial staff. They took-- And my assessment is they took their role very seriously. They had, as we can see from the KPMG report which came out, a relatively satisfactory governance structure around this. So one would have confidence that they were doing the right thing in terms of flagging this to government, but, at that stage, remember, NHS Lothian themselves did not see the entire picture.

Q Yes, okay. As I think you alluded to earlier on, after that briefing email from Alan Morrison on sort of noon on 3 July, you attended a meeting with, amongst others, Tim Davison, the NHS Lothian chief executive. If we go, please, to bundle 7, volume 1 at page 57. You should see up on screen in front of you, Professor Connaghan, a note of a meeting, a draft note of a meeting, 2 p.m. on Wednesday, 3 July 2019. Is that the meeting that you were referring to earlier in your evidence?

A Yes, it is. This is the one that came in after the note from Alan

Morrison. I don't recall reading the note from Alan Morrison before I went to the meeting, I think I probably read it afterwards.

Q Yes.

A I also note that the minute is draft, and I don't recall seeing it before the Inquiry has provided me with this draft.

Q Yes. As far as I know, it only exists in the form with draft on it, but we will proceed on the basis that this is the available note of the meeting. Now, the opening paragraph under the heading of "Welcome and Introduction" reads that:

> "John Connaghan advised that he would require to brief Malcolm Wright and the Cabinet Secretary following the meeting and that this process would require to be undertaken taken before any final decision could be acted upon."

Can you just outline your thinking in that regard about how the government's decision-making process was going to proceed?

A Well, clearly by the time we got to Wednesday, 3 July, Scottish Government wanted to make sure that any communications process was to their satisfaction. We had concerns about the fact that there were a

number of patients who would be scheduled to attend the new hospital within the course of the next few days. So we wanted certainly communications on that to be aligned. We also had, I think by that time, Wednesday, 3 July, come to the conclusion that we wanted to have absolute assurance on safety on the site, and therefore any decisions made by NHS Lothian in this respect would require to have the approval of Malcolm Wright, director general and Cabinet Secretary who, if they were not content with that, would have the power of veto.

Q Yes, and the way you put this in your statement, it is in paragraph 27, you say that:

> "I also wanted to make clear that both Malcolm Wright and the Cabinet Secretary would require to be comfortable with NHSL's proposal for opening the RHCYP/DCN given the significant potential for disruption. I had not been asked to do so by Malcolm or the Cabinet Secretary but, nonetheless, thought it was appropriate to make the position clear."

So, again, why was that something that you thought was appropriate?

A I think it was-- You probably need to read the next line on that. I thought it was appropriate because:

> "Ultimately, Ministers are accountable to parliament for the provision of health services in Scotland. Accordingly, it was only right that the Scottish Government and Cabinet Secretary were engaged in NHSL's Lothian's decision-making process."

Q Yes.

A And also, if you remember, after a long career in the NHS here and elsewhere, I had anticipated that certainly ministers, Cabinet Secretary, would want to be at the forefront of decision-making and be comfortable with the direction of travel.

Q Yes, okay. So, generally speaking, if we stand back, responsibility for healthcare building projects lies with the health boards. Just in general terms, what, in your view, are the circumstances in which it becomes appropriate for the Scottish Government to step in?

A In terms of decision-making, it's perhaps where you've got a significant failure, and clearly there was a significant failure in this particular project, so entirely appropriate. Also, you'll realise from later on in my statement where I cover escalation. If ministers are not content with the progress of a particular project – whether or not that's a service project connected with waiting time reduction or, indeed, building projects – then they reserve the right to enhance their surveillance of a board and, if necessary, in the ultimate, step in and have some direction.

Q Okay, and you quite correctly pointed out in your statement that you saw this as an issue of ministerial accountability, that ministers are accountable to Parliament for the provision of health services in Scotland. What was it about this issue that, in your view, put it into the category of ministerial accountability?

A Significant public interest, significant capital expenditure and significant risk in terms of delivery. I could go on, but I think these are probably the main things that you might be interested in.

Q By the time these issues had arisen – issues that have also arisen with the Queen Elizabeth Hospital in Glasgow – to what extent were those issues a factor in the readiness of the Scottish Government

to intervene in the RHCYP project?

A I think, absolutely, the issues of Queen Elizabeth would be in the front of the minds of folks in Scottish Government, both officials, directors and ministers. I personally did not have a lot to do with the Queen Elizabeth issues because of the nature of the task that I was employed to do, but I was certainly aware that the risks around the Queen Elizabeth read over into an interpretation of the risks, or the potential risks associated with the Royal Hospital for Children & Young People.

Q Then if we go back to the note of the meeting, so that is-- There we have it. Bundle 7, volume 1, page 57. Under the heading of "Position to Date", the note records:

> "Tim Davison advised that after significant soul searching the main punchline was that the system did not feel confident in moving the RHCYP in its totality in the forthcoming weekend and felt that it would be sensible to re-phase the process. It was pointed out that DCN could move as planned with Ambulatory Paediatric services including outpatients, therapies, programmed investigations and day surgery being able to move over the course of the next few weeks and months."

Now, if we go over the page, please, to 58, we have about halfway down the page a paragraph that reads:

> "Tim Davison commented that it had been agreed that it would be possible to move the services outlined in his introduction. The lowest risk solution was to retain the Emergency Department, inpatient, theatres and the Critical Care Unit in the current Royal Hospital for Sick Children facility."

And then further down the note, the second-last paragraph:

> "Fiona Mitchell commented that by the end of the week there would be a clearer understanding of the potential phasing of non-critical function moves and the numbers of staff involved."

And just those passages-- I accept that is not a complete summary of the note, but do you recognise those as matters that were discussed in the meeting?

A Yes, I do. The only thing that I'm thoughtful about is my recollection of "it had been agreed" as a phrase on this, but I do recall that we had some consideration of a partial move, and in fact you can see that was

one of the options we considered in that minute, wherein we considered whether or not a modular unit as proposed would be capable of deployment. But I think after that, and as we moved into the evening of the 2nd, and certainly after Alan Morrison's notes of 12.09 which preceded that meeting, were read and understood, we began to form an opinion that even a partial move would not be beneficial without an absolute assurance that risk was entirely mitigated.

Q Okay, and if we just go to page 61 of the bundle, we just see there:

> "Tim Davison undertook to produce a short note for John Connaghan and Malcolm Wright detailing the logic behind the decision to re-phase the timing of the move into the building to allow a phased occupation over the next few weeks and months."

We will see that note just in a minute, but do we see, even at the stage of that meeting, that NHS Lothian had already realised that parts, at least, of the hospital could not move?

A Sorry, could move, did you say?

Q Could not. Could not move.

A Couldn't move. Oh, yes, absolutely. If you go back to the first page you showed me – or second page, I can't remember – on this note, you will see a speculation from Tim that the move could take place over the course of the next few weeks or months. That's different from a move which is going to take place in the next couple of days, so even then I think there was a realisation that even the DCN move could be delayed.

Q Yes, and in fact we saw from the contribution recorded in the note from Fiona Mitchell that there was still a need to consider a sort of risk-based decision about what moves could happen and when.

A Absolutely. I mean, one would expect that as a normal part of the practice of assessing any move of that sort. You would take a proper risk-based assessment of the issues.

Q Okay, and then if we move on to the note that Mr Davison provided after that meeting, which is in bundle 7, volume 1, page 66. So we see on the bottom half of that page an email which is marked as being from the chief executive of NHS Lothian, so Mr Davison, and it is sent to the director general of health and social care, so Malcolm Wright, and yourself, and he says, "Malcolm and John," and

then there is an opening introduction, and just at the end of the first paragraph he says:

> "We believe the problem is capable of being resolved fully over a period of around 4 months. There are a number of options for how the solution can be arrived at and each carries a degree of risk and uncertainty.
>
> 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 that it was fully fit for purpose."

So, we see there, presumably as you would expect, NHS Lothian was prioritising patient safety and the fitness of the building for its purpose. You see that?

A Yes, I do.

Q And then reading on in the following paragraph, picking it up three or four lines from the end:

> "NHS Lothian is investigating how this issue has arisen and how best to address it in collaboration with IHS Lothian and their supply chain and is taking a range of professional advice (including legal and technical advice and advice from advisors in infection control, health and safety and facilities engineering)."

Again, presumably these are the sorts of steps that you would expect a health board to be taking.

A Yes, absolutely.

Q And then he goes on:

> "Over the last 48 hours we have considered four main options for dealing with the ventilation problem and a range of key senior staff have been consulted including clinical staff and clinical leaders, executive and senior managers, project team staff, capital planning staff, the board chair and colleagues in Scottish Government, HFS and HPS."

Again, we can see there a wide range of consultation in developing the appropriate options, and, again, is that how you would expect the Health Board to go about it?

A Yes, I couldn't fault that approach. Might want to consider whether or not that was enough, but I think we could certainly see here where NHS Lothian's thinking was going in terms of getting the best

advice they possibly could, both internally, externally and from government sources, in terms of how to address that problem.

Q Okay, and then he says that the options are outlined below, and if we just go over the page we see the first option:

> "Continue with the planned move of all services and attempt to deliver the permanent fix for the ventilation problem while the critical care unit remains occupied [and we see that that option was not supported]."

Then the second option:

"Continue with the planned move of all services and then decant critical care [and again, we see that that option was not supported]."

Then if we go over the page, the third option, "Defer moving in to the new building altogether," and what he says about that is that this option was not supported because:

> "…the rephrasing(sic) of the move of the critical care unit only really affects those services dealing with the sickest of paediatric patients [and so on]. It does not materially impact on DCN services and ambulatory paediatric services and therefore there is no need to defer these elements of the move."

And then his fourth option:

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

Then he says:

"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."

Then he says:

"Following my meeting with senior colleagues this afternoon (which John attended), we agreed the following immediate actions:

- Develop a communications plan between [the Scottish Government] and NHSL…

• Commission the permanent solution for the ventilation issue in critical care."

And then he says, "Clinically risk assess and plan the re-phased moves described in option 4."

So, does that email fairly set out what you understood to be NHS Lothian's thinking at the time?

A Yes, that fairly reflects NHS Lothian's thinking at the time. I don't recall in the meeting that we had prior to that, which was a two o'clock meeting, and this email was sent, I think, at 4.36, that we had gone into any substance of rephasing. So all of that would be new to us in terms of understanding all of the options about moving into an empty ward without clinical risk and with limited disruption, etc., etc. So I think it reflected where the chief exec and the team would want to head at that particular point in time.

Q Okay, so at this time, 4.36 on the afternoon of 3 July, perhaps understandably, all of the information is being gathered and all of the optioneering is being done by NHS Lothian.

A Yes.

Q And what Mr Davison is doing is sharing that openly with the

government.

A He is, and in the meantime, as we have already observed, the government itself was taking its advice from other sources, and I referenced the Alan Morrison email of 12.09, same day.

Q And when you say other sources, do you mean that the government was taking information from somebody different?

A No, I'm referencing the email where Alan Morrison is reporting back on a conversation that he's had with the HDFS and HPS. That's the one that you showed me at 12.09 prior to this note.

Q Yes. I think what Mr Morrison says is that that had been a meeting with Tim Davison as well.

A Oh, that's fine, yeah. But the government also will be taking advice from that meeting with Tim Davison, HFS and HPS, so that's the way I'm just referencing that, if that's helpful.

Q I am sorry, I am just trying to be clear about whether there were sources of information available to the government at this point in time that were not available to NHS Lothian.

A No, we would work on the basis of complete openness on

this. I'm merely referencing the fact that government is taking advice from Tim Davison and HFS and HPS in the meeting that took place at 12.09.

Q Yes, thank you. Rather than reassure you, you indicate in your statement that this email actually raised concerns in your mind. Can you just explain why?

A Could you just reference me the section of my statement on that, just so that I can refresh my memory?

Q Yes, of course. It is paragraph 36 of your statement.

A Yeah, indeed. So, I highlight in paragraph 36 three areas of concern:

> "Communications to patients and staff need to be clear and consistent to avoid confusion."

This is one aspect of split-site working. So, the general population had understood through a very extensive advertising campaign, for example on the backs of Lothian buses, "on the move." So there would be many hundreds of patients that would be streaming through that hospital, some of them with planned attendances, others with emergency attendances over the immediate days. So the communication to say some of that is going to move and some of it is not, how does the general public understand that? So that was what lay behind my concern on:

> "Communications to patients and staff needing to be absolutely clear and consistent to avoid confusion."

And, secondly, the concept of split-site working might prove problematic operationally, given the scale. I happen to recall – I'm not quite sure where I can reference it – a piece of information about the combined anaesthetic rotas, which would operate, and where those anaesthetic rotas might be at risk, in terms of being able to cover the entirety of services if operating on two different sites.

Q Yes, okay.

A As an example. And the third one was the thought that I've already evinced on whether or not the critical care ventilation issue was the only one that was in existence at the time.

Q Yes, okay.

A And without that assurance from HFS, HPS, and others, including all of what you've referenced in that note from Tim Davison to myself and Malcolm, that was the thought process at that time.

Q Okay, and as we saw from Mr Davison's email, he was signed up to the need to develop a communications plan----

A Yes.

Q -- and also to the need for risk assessing and planning the phasing of the moves. So, not much difference really between you and Mr Davison, in terms of the issues that had to be kept in mind?

A No, and if I reference you back to part of the minute of the meeting at two o'clock, I think I had said something in there that, "No communications were to be issued without CAPSEC approval."

Q Yes, okay. Then the next day, so this is 4 July, Malcolm Wright sent a letter to Mr Davison, and that letter is at bundle 7, volume 1, page 79. I think this is the letter you might have referred to a moment or two ago.

A Yes, indeed.

Q What you say in your statement about this is that this letter was issued following a meeting that the Cabinet Secretary had had with her ministerial advisers, and it reflects the Cabinet Secretary's decisions at that meeting about how to proceed. Is that correct?

A Correct.

Q As we will see, the letter set out various actions for the Health Board to undertake. If we just read from the opening of the letter, it says:

> "Dear Tim, you advised me on the ventilation issues in the new Edinburgh Children's Hospital on the RIE site on Tuesday afternoon of this week. I can confirm that following the further information that has emerged over the course of yesterday and last night, that the Cabinet Secretary has taken the decision to halt the planned move of the Edinburgh Children's Hospital and the Department of Clinical Neurosciences for the time being."

So, just pause there. Does that reflect the decision by the Cabinet Secretary that decisions about the hospital move should be made by her?

A Yes. I mean, it's quite clear in this letter that the director general is following the line from the Cabinet Secretary about decision-making.

Q The evidence of Mr Davison, NHS Lothian's chief executive at the time, was that this decision was announced publicly before NHS Lothian were told about it. As far as you know, was that the

case?

A I can't say what other communication Mr Davison might have had, either from the Cabinet Secretary direct to the chair or from the director general in any conversation with Mr Davison, but I can recall on the evening of 3 July having a conversation with Mr Davison, which I think is referenced by means of a phone call from me to him around about 8.30 at night, which is in my statement I think, where we agreed that the communications plan, as currently constructed by NHS Lothian, would be halted.

Q Yes, but my question is around this issue of whether Mr Davison is right that the Cabinet Secretary's decision to halt the move had been publicly revealed before NHS Lothian themselves had been told about it.

A I can't-- As I said earlier, I can't say what other communication stream came to Tim Davison about that fact, so I'm sure you can ask others, and all I can do is repeat that on the preceding evening, Tim and I had a conversation about not proceeding with the planned move and with the communications plan that was then extant, which intimated that NHS Lothian's DCN part would move as

planned. Okay? That was a conversation that took place the night before, and it's evidenced, I think, in a note that Tim has sent to his exec team at around 9.30 that previous night. So, I think Tim might well have had some knowledge about the pause that we wanted to have on that move the night before this.

Q But was the decision to have the pause not taken at the meeting on 4 July by the Cabinet Secretary with her advisers?

A Yeah, I think the meeting on 4 July formalised that, okay? But given that the meeting wasn't happening until 4 July later in the day, it would have compromised the Cabinet Secretary's position to have briefing commencing at nine o'clock on 4 July prior to that meeting taking place. So this was a precaution to make sure that the Cabinet Secretary would be comfortable with that, and that's why that meeting took place with advisers and why that note was issued on 4 July, I think in the afternoon.

Q Just so I can be clear about it, Professor Connaghan, are you saying that Tim Davison was told the night before that the move wasn't to happen?

A I think Tim Davison was advised by me that no communications

should issue on any planned move until the Cabinet Secretary considered that the next day.

Q That is not really what I asked you. It is the question of when Tim Davison was told that the move was not to go ahead on the orders of the Cabinet Secretary.

A Well, that would be----

Q Was it the evening of 3 July, or was it by this letter on 4 July?

A So, formally on 4 July, yes. Okay? Formally on 4 July, yes, but the conversation that I've just relayed asked Tim to pause that communication until such time as we had formalised the position at the meeting and issued this note on 4 July. So the 4 July note that we see in front of us is the one which formally advised NHS Lothian that move should be paused.

Q Yes, and what Mr Davison says is that that news, the Cabinet Secretary's decision to halt the move, was revealed to the public before it was revealed to NHS Lothian.

A Well, I can't comment on that. I'm not quite sure when it was revealed in public. Communications colleagues would be able to advise on that.

Q And if that was the case, what would your views be about the

appropriateness of it?

A Depends on, I suppose, what communications come in to Scottish Government. Ministers, given that I've previously stated they're accountable to Parliament for the operation and delivery of health services, if they're faced with a question on this coming in from the press about, "Is the facility moving or not," would probably want to answer that to the best of their ability.

Q Okay, but in the context of a meeting, behind closed doors presumably, where a decision is taken that the hospital is not to open, it would seem quite a straightforward step to pick up the phone to Mr Davison and tell him first.

A Yes, I would agree with that that.

Q Do you accept that if it is revealed to the public before it is revealed to the Health Board, that that has at least the potential to be disruptive and demotivating to those working at the Health Board?

A I cannot fully agree with that. I've already explained that if ministers are asked a question, either through Parliament or indeed through the press, then I think they probably have to answer that to the best of their ability at the time. I would understand

that it would be normal, if that happened, to communicate this immediately to the Health Board. I'm not quite sure, and I can't answer, what communication took place between Scottish Government and NHS Lothian on the morning of 4 July.

Q Okay. To what extent was the Cabinet Secretary's decision about how to proceed different from the plans that Mr Davison had outlined the day before?

A I think we need to look at the second page of this note of 4 July. Okay? The critical thing that's different in this note, I think, is the top of page 80 which is:

> "We need as a matter of urgency a revised migration plan for Clinical Neurosciences."

I'm sure that in this note there is a requirement, it is indeed:

> "I require that you involve both HPS and HFS in the scrutiny of that migration plan and their assurance to us that there are no technical or safety issues that remain outstanding. I shall also require a clinical safety assessment of the planned re-sequencing of moves to ensure that at the very least there are no clinical interdependency issues [aka split-site working] that now occur where patient care could be in any way sub-optimal."

So that sentence there places an additional burden of assurance on the Health Board, which is not, I think, absolutely evident in the proposal to accept the move of DCN, as planned on 9 April.

Q What Mr Davison had indicated was a recognition of the need to risk assess any phased migration.

A I would agree with that.

Q He had already demonstrated, through actually doing it, a willingness to consult with HFS and HPS.

A I would also agree with that, but we still had to receive HPS and HFS reports on such matters, so we would not want to proceed without having them available.

Q If you go back to the start of the letter at the end of the opening paragraph, Mr Wright says there that:

> "As I have already advised you, this is taken in the best interest of patient safety and to ensure that we provide sufficient time for the resolution of the ventilation issues."

Now, the prioritisation of patient safety, that is the same spirit in which Tim Davison was approaching matters.

Is that fair?

A Absolutely. I think that Tim's value set would put the best interest of patient safety first. So we were in an absolute accord with that, there's no differentiation.

Q Then the first action required of the Health Board is to put in place and maintain a communications plan, and that is something which Mr Davison had, the day before, indicated that he was entirely in agreement with.

A Yes, agreed. I think the intention here is that Scottish Government Communications Department also needed to be involved, and that the briefing to the Cabinet Secretary would ensure that she was also content with the communications plan.

Q Okay, and, again, just picking up at the end of that first paragraph, Mr Wright says, "There are a number of actions that I now require you to undertake," and those are listed in the bullets. Then if we go to the end of the letter, he says:

> "I require your immediate confirmation and understanding of the terms of this letter and the points raised."

Now, one can see that asking for immediate confirmation and understanding reflects the gravity of the situation.

A Correct.

Q And also the need for clear communication, but is it fair to point out that Mr Davison had himself already raised these issues, and thereby demonstrated that he already understood the gravity of the situation?

A I think that's absolutely fair. I think Mr Davison and the executive team in NHS Lothian took this very seriously and very professionally. I think this letter here, as I've previously explained, goes a little bit further in terms of seeking direct assurances from other bodies, but it essentially reflects, I think, where Tim is, but it needs to be the formal communication from Scottish Government to NHS Lothian for the record.

Q Yes, and I think it is fair to acknowledge that the letter does set out requirements for assurance on certain things which Mr Davison himself had not raised.

A Yeah, and if you go to the first page of this again, page 79, second paragraph:

> "I also require an assurance that there are no other material specification deficiencies in the new building."

That is an addition, I think, to Mr Davison's previous communication on that matter.

Q Yes, but as we have seen, several of the points or the action points that the letter was imposing upon NHS Lothian were points that Mr Davison himself had already raised.

A Indeed. So, there was a fair degree of accord between the Scottish Government and Lothian Health on this matter.

Q Now, Ms Freeman, in her own witness statement, acknowledges that some might describe her approach to this issue as having been "too high-handed." Those are the words that she uses. What were your views about it?

A I think the Cabinet Secretary's consideration of this was entirely appropriate. If government operated in a vacuum on this, without transferring previous knowledge of the Queen Elizabeth issues, in terms of consideration of the issues that could potentially face the new Royal Hospital for Children & Young People, then I think they would be rather remiss in not doing that. So I think Scottish Government colleagues, Cabinet Secretary, were entirely appropriate to operate in this sphere.

Q Is there room for the view that a more collaborative tone might have been preferable?

A In what respect? In terms of the drafting of this note?

Q In terms of the drafting of the note and the failure, if indeed it is the failure, to tell Mr Davison about it before it was publicly announced?

A I think you need to understand the level of anxiety that was in the system at this time. We needed to be absolutely precise. There should be no room for equivocation in terms of what Scottish Government were requiring the Health Board to do at that stage. So I think the note was drafted to be as precise as it possibly could, and also I think what was unusual from a note sent from the director general to a chief executive is to ask, "Do you understand what lies behind this note?" Okay? And that, obviously, came back from Tim either the same day or the next day. So, there's a requirement to be absolutely precise, I think, is what lies behind the tone of this note.

Q Yes, I appreciate that this was a period of time where events were moving quickly and people had limited information and so on, but standing back from that, when it

comes to government intervention in the work of a health board, is there a risk that the wrong approach serves to undermine morale at the health board and, perhaps, also public confidence in the health board at precisely the time when the opposite is needed?

A I think there's always a risk of that and we would seek to mitigate that risk by having not just written but personal contact, as you can see with the executive team and Tim over the days that followed. So, I think I did say in my statement somewhere, if I can find it, that-- if I was satisfied with how NHS Lothian handled matters following the discovery of the critical care issue. Personally, I was, at the time, relatively happy that they had reacted in that week to take matters exceptionally seriously, and in dealing with Tim Davison and indeed his officers in the early stages of this, I personally found that NHS Lothian were open to answering any questions that I had on various aspects of communication or operational issues. I also recall that the Cabinet Secretary and director general visited DCN and, I think, the existing old Sick Kids, to talk to staff about this and to provide some reassurance.

Q Yes, so that was your

view of it, but when one reads that letter against the backdrop of Mr Davison's communications to the government, one might read the letter and conclude that the government had lost faith in NHS Lothian's ability to make the decisions. Was that the attitude that underlay the letter?

A No, the attitude that underlay the letter was to seek absolute assurance. It's quite clear in that we have, at no point in that letter, said anything about our confidence in NHS Lothian pursuing the solutions that they needed to pursue. Later on, I think, I can't remember if it was that week or the week afterwards, it was determined that NHS Lothian would benefit from some further help from government through the escalation process, which is where the Oversight Board came in. But, clearly, having personally known the execs in NHS Lothian and been around Scottish Government for some time, we saw NHS Lothian as a very credible management team.

Q Okay, and you mentioned in your answer there the escalation of NHS Lothian on the NHS Scotland Support and Intervention Framework. You deal with this in your statement, and the escalation was first of all to Level 3 and then at a later

stage, in relation to the Sick Kids project, to Level 4. Can you just explain for us what the NHS Scotland Support and Intervention Framework is, and what purpose it serves?

A Okay, there are a number of stages in the NHS Support and Escalation Framework, five stages, as I recall. I think these might be contained in an annex to my statement, Appendix A, I think it is, and these range from Stage 1, Steady State, through to Stage 2, Enhanced Monitoring and Supports, and essentially----

Q Sorry to interrupt you, Professor Connaghan. It might help if we-- We can bring the document up on screen. Bundle 13, Volume 3, page 687. I am not sure if this is the exact same document that you had appended to your statement, but I think it may help you in answering this question.

A So, thank you for that.

Q Just for the record, I should point out, this is a version from November 2023. So I think this is probably the current version, perhaps not the precise version, but for present purposes it will serve our purposes.

A It will serve our purposes admirably and, in fact, it's much the same version that we operated in then. So, in broad terms, five stages of a ladder of escalation. Stage 1, Steady State, Board are delivering in line with agreed plans, normal reporting arrangements in place. If we see a drift from plan, we might move to Stage 2, which is Enhanced Monitoring. We ask for more reports over a shorter time period to make sure that things are on track.

I would characterise Stage 3, where we have Enhanced Monitoring support, where there's a much more formal approach incorporating significantly enhanced scrutiny and likely to include a level of external support. That is where we placed NHS Lothian in relation to the performance issues that they were facing on cancer, outpatient waiting times, inpatient waiting times, mental health, etc. That was the level of escalation applied to that aspect.

Later on, there was a consideration of what level of support NHS Lothian might require in relation to the building project itself. That was a different form of escalation, with the creation of an oversight board which was chaired by a different director, and that was Stage 4, Senior External Support and Monitoring, and that, obviously, is much more formal. It's where we consider that there are

significant risks arising and that we need to support the Board in terms of tackling those risks.

I should say that one of the considerations – the Inquiry might be interested in this – in terms of moving to Level 3 for the performance criteria, was a consideration of the wider tasks that now had to be undertaken by the NHS Lothian executive team. They've not only had to deal with the normal performance challenges that exist all the time in the NHS, but they also had to deal with the rectification of the issues surrounding the Sick Children's Hospital.

Q Okay, that was very helpful, and I will just go back over the different elements to it. First of all, just focusing for the time being not so much on the project -specific application of it, but just the framework itself. When you were giving your answer, and we can also see it through the note that is up on the screen, a term that often appears there is "support," and I think you emphasise in your statement it is a support mechanism and not a punishment. I would just like to ask you about that because it may sometimes be perceived differently by the public and perhaps by the health boards themselves. Could I ask you to

expand on that point, that it is support rather than punishment?

A I can well see-- I can well see why, depending on the circumstances, a health board might think, "Well, this is punitive, we're doing okay." But in terms of the wider risk assessment against delivery of ministerial objectives, the Scottish Government has to have a mechanism of enhanced scrutiny, but also providing support. I actually drafted the original Scotland Support and Intervention Framework many years ago, and it was always set up with the intention of support to our Board.

This is evidenced in the Stage 3 escalation, where the support we provided to NHS Lothian was the creation of-- and I might not have the term exactly right here, but a director of improvement. That director of improvement was employed and successfully tackled some of the performance issues with the management team, allowing a little bit of space. That's an example of support. It's not an example of punishment.

Q Okay, so is this framework the standard means for deciding upon the degree and nature and timing of governmental intervention in the work of health

boards?

A It is. It provides that framework, a rationale for government engagement in this but, as every large complex system operates, you'll know that there are many other either short-term interventions that government might do with boards, but without going to any formality in terms of escalation. These things happen on a 24/7 basis as the NHS operates. So this is a formal aspect of support and intervention.

Q Okay. I think you say in your statement that the framework applies only to the territorial health boards. Why is that?

A Yes, there were different sponsorship arrangements with what we call special boards. These are boards with an individual, particular task. We would tailor support, if a special board had issues, specifically for that set of circumstances. If, for example, a special board had a big IT issue, then we would tailor support in that fashion. I would say that we would probably lift some of that structure in applying to special health boards.

Q Okay. How are decisions made about escalation?

A We would observe against the standards that we wanted

to achieve, the relative degree of risk in that board achieving those. We would observe this through the data that we'd gather on a weekly, monthly and quarterly basis. We would previously have agreed with a health board an annual delivery plan. We've used various terms for that over the years, local delivery plan, annual delivery plan. It really means the same thing. What is the business plan for the year ahead? We would agree the parameters for delivery, the milestones that needed to be achieved, and we would regularly observe that through the data that was coming back from boards as to whether or not we were on or off track.

The decision-- Sorry, and the last thing is, to answer your question fully, the decision-making around that would be especially if we're moving into a Levels 3/4 in the Escalation Framework, really around Health and Social Care Management Board with associated data and with a recommendation on how we should proceed.

Q Okay, so is it the Health and Social Care Management Board that is the decision-making organ in relation to escalation?

A Correct, for Levels 3 and 4, which are the more formal aspects.

For Level 5, it's the Cabinet Secretary.

Q Yes, okay.

A Sorry, one other thing. In going to Level 3 or 4, the Cabinet Secretary would be appraised, and we'd want to make sure that he or she was comfortable with that direction of travel.

Q Yes, right. I think you say in your statement that at the time of NHS Lothian's escalations in relation to this project, you were the principal advisor to the Health and Social Care Management Board on the level of escalation required. Is that correct?

A Correct, and for the performance elements of that for Level 3.

Q Okay.

A Not for the building projects which would be outwith my sphere of expertise.

Q Okay. If we can have a look at the report you prepared in this regard, that is at bundle 3-- sorry, bundle 13, volume 3, page 683.

A Yes.

Q So, you recognise this, we see your name----

A I recognise that, and I'm not exactly the author, but I'm the director that signed off that report.

Q Okay. We see it is dated 9 July 2019, and in the box reading "Background and Key Issues," it says:

> "Recent identification of issues around the new Royal Hospital for Children & Young People are considered in the context of wider performance and other issues related to NHS Lothian."

And so we see there, there is a context. This is not just about the Royal Hospital for Children & Young People.

A Correct, and that's commensurate with my previous statement that-- where we take a look at the wider risk landscape, a concern that NHS Lothian executive team would be consumed with the "fix", so to speak, of the children's hospital, as well as dealing with a very demanding agenda as the second largest board in Scotland.

Q Okay, and if we move over the page, we see a little bit more detail around that.

A Yes.

Q So the box headed up, "What are the current challenges?" Then in the first paragraph, just picking up about halfway through, it is explained that there were, or rather that "an issue related to paediatric critical care ventilation had been

raised." Then the following paragraph, just picking up three lines from the end, it says:

> "It is expected that it will take at least six months for the problem to be resolved, but further work is required to test and validate the proposed solution and estimated timeline."

So that is talking about the critical care ventilation issue, as I understand it.

A Yes, I think it does, and it might well be that that six months incorporates the three or four months it would take for HFS, HPS to do whatever work was agreed between them and the Scottish Government, and I don't know much about that side in terms of technicalities, but that would be roughly our understanding at that point in time of the timescale.

Q Okay, well, and that might be answered a bit by the following paragraph which reads that:

> "In the meantime, the Cabinet Secretary has asked that an external series of checks is undertaken, led by Health Facilities Scotland and Health Protection Scotland, to ensure that all the relevant technical specifications and standards applicable to the new Edinburgh Children's Hospital are being followed and implemented."

So, do we see there that this is a-- it is not just about the critical care ventilation, but there is a wider programme of work envisaged by the Cabinet Secretary in relation to the broader compliance of the hospital with standards?

A Yes, indeed, and this isn't quite the document to go into the detail of that, as you'll understand, which is why it's-- for those who drafted it, it's simply a reference to that.

Q Yes. I mean, just in very short terms, was this proposal identifying or recognising that the Cabinet Secretary's intervention was going to mean more work for the Health Board?

A Oh, absolutely. Indeed, you know, if you can consider that we've already seen extensive involvement of the Board and the executive team in resolving the issue, quite clearly we had a concern that the other issues we're pursuing around performance, cancer and waiting times and mental health, we wanted to ensure that Lothian were supported in as much as it possibly could.

Q Okay. I appreciate that

there are other issues going on in the background, but was it that additional programme of work which was the key consideration behind the escalation to Level 3 at that point in time?

A No, not necessarily. I was concerned, and I'm wearing my Scottish Government-- Understand I wear two hats now.

Q Yes, indeed.

A Okay, and I need to be careful which hat I'm wearing, but I'm wearing the hat of Scottish Government. I was concerned, for example, about cancer waits. March 2018, the cancer performance for Lothian was 87.2 per cent, for the 62-day standard. It had drifted somewhat to-- down to 81 per cent by December 2018, and my observation was in March 2019 it was further down to 79.4 per cent within standard. So that was a direction of travel that Scottish Government would not want to have and, similarly, increases in the numbers waiting for inpatient and outpatient treatment over 12 weeks, but some notable successes and other factors as well. So a credit where credit is due, but all of that and with a wish that NHS Lothian, the exec team tackled this as well as the issues of the Sick Kids, that was a contributory factor and the major factor of the

escalation.

A Yes. Okay, and then we can see the letter sent by Mr Wright following the decision to escalate NHS Lothian to Level 3, and that is bundle 7, volume 1, page 339. We do not need to read this letter, but we can see an explanation from Mr Wright which is along the lines of the one that you have just given, and if we go over the page to page 340, he says:

> "Before we meet next week, I would ask you and your senior team to give consideration to the nature of improvement and support that you would require to take this forward."

So, Mr Wright is inviting Mr Davison to come up with suggestions for the appropriate form of support.

A Yes, indeed. So, I would have engaged with NHS Lothian on answering that question and I do recall-- though it is not in any of the material that we have here, I do recall having several meetings with NHS Lothian over the weeks and months to come on that level of support which, as we engaged with Lothian in resolving some of the performance issues, the nature of that support would have changed. I've already referenced, for example, the creation of a director of improvement team, but we would have

sought some help from, for example, the Golden Jubilee to take some of the longest waiting patients to resolve their cases as quickly as possible, as an example of the kind of support.

Q Okay, and is it the normal approach to these things that the government will invite ideas from the Health Board about the form of support that is appropriate?

A Yes, indeed. Certainly, at this level of escalation, and the level of confidence that we had in NHS Lothian as previously a very high performing team is reflected in that paragraph there. It's also in terms of our general value that it's best to have complete ownership of the solution, yeah? Government can support various thinkings around what that solution should be, but it's much better in terms of delivery if the solution is owned by the local health board.

Q Thank you. My Lord, I note that it has just gone past one o'clock. I still have a series of questions for Professor Connaghan, and that may be a convenient time to stop for lunch.

THE CHAIR: Yes. Professor Connaghan, we usually take an hour for lunch. Can I ask you to be back for two o'clock?

THE WITNESS: Certainly, my Lord.

THE CHAIR: Yes.

(Adjourned for a short time)

THE CHAIR: Good afternoon, Professor Connaghan. Mr McClelland.

MR MCCLELLAND: Thank you, my Lord. Professor Connaghan, you will remember that before lunch I was asking you about the Cabinet Secretary's decision to halt the opening of the hospital, and, in that context, I was asking you about the relative timing of the decision being announced to the public or revealed to the public and being disclosed to NHS Lothian. Do you recall that?

A I do recall that.

Q There was just a document that I should put to you for completeness. That is at bundle 7, volume 1, page 98, and you should see there it is an email from Calum Henderson, the Assistant Private Secretary to Malcolm Wright, to Mr Davison dated 4 July 2019, and we see there that the email is timed at ten past four in the afternoon.

A Okay.

Q I understand that that is the email which sent out Malcolm Wright's letter that we were looking at this morning to Mr Davison. So that

may indicate when the correspondence was sent to Malcolm Wright. Do you know when the meeting took place at which the content of that letter was worked out?

A It certainly wasn't first thing in the morning. If I'm going to give you a broad recollection of time – and it's a number of years now – I think it was something like either late morning or early afternoon; but most likely that meeting, I think, was late morning, but that's the best I can recollect on that.

Q Okay, and is it correct that the letter was drafted up after the meeting?

A The final letter was drafted up after the meeting. I do recall that there was a draft of sorts that we looked at in the meeting, but that was only a very rough draft.

Q Okay. That is helpful, thank you. If I could return, then, to the subject of escalation, you explain in your statement that NHS Lothian – having been escalated to Level 3 as we discussed this morning – was then escalated to Level 4 in September 2019, and that particular escalation was in respect of the RHCYP issues only. Is that correct?

A Correct.

Q And was that a response

to the reports which had by then been produced by NHS, NSS and KPMG?

A I couldn't tell you about the rationale for that particular oversight board and that level of escalation. That would have to be somebody like Christine McLaughlin, I believe, who was the first chair of that; but if you're asking me to give you an opinion on that, then that would certainly seem sensible that those reports were looked at and part of the decision-making. I'm almost sure that there would have been a letter to Lothian on that escalation to Level 4 which set out the rationale.

Q In fact, if we go to paragraph 66 of your statement, which is in witness bundle volume 1, at page 234, it is paragraph 66, and we see there that you're addressing the question of the relationship between the NSS review and the KPMG audit and the escalation to Level 4, and what you do is you quote from a report prepared by Christine McLaughlin in respect of that escalation.

A Correct.

Q And just reading from what she says, picking up from the second paragraph – this is you quoting her – she says:

"We have also received the two independent reports into the

> Royal Hospital for Children and Young People. Taken together and based on advice from the Oversight Board for the RHCYP, our assessment is that there are a broader range of issues that require to be addressed before the building can be fit for occupation."

Is it your understanding that the NSS report had identified a broader range of issues to be addressed before the building----

A To be honest, I can't recall at that stage anything connected with the NSS report, but if I can say I would be surprised if that was not taken into account.

Q Okay, that is fine. And, again, if you do not know the answer to this, then please say, but was it the case that the escalation to Level 4 was what allowed the Scottish Government to provide additional managerial support in the form of Mary Morgan?

A Absolutely. Parts of the rationale for moving to Level 4 escalation, which is quite a significant and, in our view, serious step in terms of an escalation process, is that an oversight board is constructed. We don't normally have that for Level 3, which is of a lower level of dialogue and engagement, but with the creation of an oversight board we normally want to have a chair, as well as, perhaps, the injection of additional expert help from outside the organisation. Mary Morgan was that, I think.

Q Okay. So, we have seen, then, escalation to Level 3, then escalation to Level 4 in relation to the project itself. In the context of the project to build the hospital as a whole, these escalations in the support framework came at the end, effectively, in order to deal with remedial works. Is there a case for saying that the government's support came too late in that the Health Board really should have been given more support for the project at an earlier stage?

A Well, of course, we didn't know about these issues before July, okay? As I've said earlier, we had confidence in Lothian, as we do in other boards in Scotland. You know, it's not just Lothian that's taking forward big projects of that sort. We had confidence in Lothian and the other boards that they were efficiently equipped, both from an internal management perspective as well as from external technical advice, to be able to successfully deliver a project. So I wouldn't necessarily say that that

was the case; but remember of course that each NHS board is subject to mid-year review and annual reviews, and we assess the risk of delivery of various things in those reviews. Those annual reviews are chaired by a cabinet secretary and held in public and there's a record of all of that.

Q Okay, but building an acute hospital is a complicated thing to do. You accept that?

A Absolutely.

Q And doing it under a PFI or private finance-style project structure brings probably extra complications to the task. Would you agree with that too?

A I broadly agree with that.

Q And we have heard evidence that many people within a health board, if they are doing it anytime in their careers, may only do it once.

A It depends. That may be true, but I think you've alluded to that earlier before lunch, and I made the point that bigger health boards would perhaps have even several projects ongoing at the same time, so there'd be a degree of embedded expertise in the bigger health boards. I'm not so sure about smaller health boards. They might only have one project every dozen years of that ilk that needs that level of expertise injected into it, so I'd just qualify that answer a little bit.

Q Okay. If I just put this question to you, do you think there is sufficient recognition of the relative degree of inexperience in that sort of big building project in the way that the NHS goes about its construction projects?

A I think there's a recognition that if I take a larger board, it might well be able to have more internal resources and less reliance on external advice, so there's more capability in there, but I would probably agree with you that for smaller health boards that don't have that critical mass, that might not have approached a programme of that size for a number of years, we need to think very carefully, now and perhaps in the future, about how we support them, and indeed that brings us on to NHS Assure.

Q Yes. In general terms, given your current role as the chair of a health board, how do you view NHS Assure and the approach that it takes to this type of thing?

A Well, let me just say a couple of things in context before I directly answer that. The contextual point here is most, if not all, big

building projects in Scotland are paused because of financial considerations about availability of capital. So, the first contextual point I want to make is that that gives us a little bit of time to be able to consider what lies behind the NHS Assure process and what boards might need to have in place, okay?

I think there's a very important point made by some of the previous witnesses to this Inquiry about the level of resource that might be required, and if I pick infection prevention and control nursing as an example, that is needed to support the aims and objectives of NHS Assure. There are questions there about, how do we have sufficient national training, and I'll use the word "standards" again, in terms of what we would expect as a response from health boards to input into that process, and I think that still needs to be worked through and we've got a bit of time to do it.

But my general impression is that I welcome NHS Assure. I particularly welcome the concept of key stage assurance reviews, which are inserted into the process as checks and balances for what we do. The last comment is, while I think I'm comfortable in terms of how the lines of accountability work between NHS

Assure and health boards, I just wonder if that's sufficiently clear to everyone.

Q Okay, and you are referring there to the fact that responsibility for the project and their compliance with guidance and standards and so on remains with the health boards, despite the fact that there is perhaps a growing body of expertise within NHS Assure?

A Yes. It depends on where you put that level of accountability, but you could extend that concept to other bodies for assurance like, for instance, Healthcare Inspection Scotland, HIS in short. So I just wonder if it's sufficiently understood where those lines of accountability lie. I'm quite clear, and I think probably most senior leaders are, but others might need to be just a bit assured.

The reason I reference that is that I read the target operating model which is contained in the bundle, which had a reference in – and this might have been a draft – to joint accountability. I also read the reference after that on Assure in terms of the letter that came from Richard McCallum to the service introducing Assure, which made it clear that there was a split accountability there.

Boards are accountable for projects and I think we might want to reconcile that, but I may have been reading a draft of that first document, the target operating model, so I might not reference it correctly.

Q Okay. Now, you have been clear that you understand the intention is that the responsibility for the projects themselves remains with the health boards. Do you think that that is the right approach to take?

A Absolutely. NHS boards are legal entities. They have, of course, got a line of accountability through the director general to the permanent secretary for financial matters, and indeed the Cabinet Secretary, as I previously referenced, is accountable for the delivery of healthcare services to Parliament. I think inserting another level or parallel accountability would be unworkable.

Q And when you say "unworkable", in what sense?

A Confusion. Who's in charge? Who makes the decisions, etc., etc.

Q Do you see it as important to identify, insofar as possible, a single point of responsibility for the project?

A Yes, I believe that's important, but that single level of

accountability actually exists just now. I think we call it senior responsible officer, SRO for short, with a relationship to the accountable officer for the Board, which is obviously the chief exec. That's quite a common framework for delivery of projects.

Q So, Assure is built on the idea that that responsibility remains firmly in the Health Board. Thinking more broadly about it, is there a case for having major healthcare construction projects run not by the health boards, but by a centralised body where, you know, perhaps for the whole of the NHS in Scotland, where a pool of experience and expertise can be built up over several projects?

A I'm not aware of any developed Western nation involved in the level of healthcare that we would understand that has that as a key part of its operational response to that. I think there's possibly a good case to be made for a central repository of knowledge, and I think NHS Assure attempts to do that, but I would still leave, in terms of my previous answer, accountability with boards. I don't think it would entirely be workable if everything was centralised. However, I have an open mind, it would be good to be able to see the benefit and risks analysis of such an approach.

Q Are there risks and potential disadvantages in building up a pool of expertise in one part of the NHS, so NHS Assure, but leaving the responsibility for the running of the projects and so on in a different part of the NHS? Is there not a case for combining the two in the same place?

A Well, I think you're asking me then, should we combine accountability? And I think I've already said that I don't think that's a wise thing, okay? So I would, very simple, just keep it separate.

Q Okay. Most of the questions I have been asking you today have been in relation to your hat that you formerly wore as a member of the Scottish Government, or an official in the Scottish Government. Could I ask you now to put on your hat as the chair of NHS Lothian?

A Okay.

Q Are you aware that in response to the critical care ventilation issues at the RHCYP, that NHS Lothian commissioned a report from Grant Thornton into their governance and internal controls on the project?

A Yes, yes, I am.

Q And are you aware that Grant Thornton, at the end of their report, made various recommendations for NHS Lothian to strengthen those internal controls?

A Yes, there were, as I recall, six broad categories of recommendation and a rationale for that, and I also recall the Grant Thornton report had an initial management response against each of those six recommendations.

Q Okay. Has NHS Lothian taken steps to implement those recommendations?

A Yes, it has. If you do the audit trail of what happened to that report, you will see senior officers in NHS Lothian being assigned responsibility, principally director of finance, but also director of capital, to take forward various elements of those reports. You will be able to track the progress of that through our Finance and Resources Committees, Audit and Risk Committee, and eventually our Board. You will be able to see the development against each of those recommendations, a particular framework; that framework again passing through the various authorisation levels.

So I think in answer to this, we are today-- and this is-- I know that you've had evidence from Susan Goldsmith, this work continued well after and continues today beyond Susan Goldsmith with our current

director of finance, Craig Marriott, and others. So I think we can reference that we have adequately dealt with each of the recommendations.

The one thing I would say though, is that because of the pause in capital projects, it is our desire to be able to test that in a real, live situation. We've not really been able-- We've started to do that, but we've not able to finish that because of the pause in projects. And the last thing I would say about this is that we should view these frameworks as ever changing. We're going to keep them as a live document, various versions will come back through our Board, and the reason it's a live document is that we want to learn from the Inquiry, but we also want to understand what's happening elsewhere in Scotland as a reference point.

Q Okay, so can I take it from that that NHS Lothian is taking more into account than simply the recommendations made by Grant Thornton, but thinking more widely about how to address these issues of project control and governance and so on?

A Yes, but driven largely by the original Grant Thornton report. I mean, it raises a question about-- which is in my mind, and I haven't

made a view on this either way, as to whether or not the framework we have developed in response to the Grant Thornton recommendations should form the basis of some national view of what's right for a kind of framework. I haven't come to a conclusion either way, but just to say that our framework is available – I think it's available on our website, I'll just check that – but we have circulated it also to the Scottish Government and other colleagues, and we continuously develop it.

Q So, just to make sure I have understood that, you mean that whilst this is something that NHS Lothian has developed for its own purposes, it is potentially something of use to other Health Boards around the country?

A Could be. Could be. I'm not aware of the other frameworks that other boards might have in this area. So it begs the question, if we've done the work in response to Grant Thornton, how useful is that in terms of forming part of the governance of projects elsewhere in Scotland? As I say, I haven't-- it's just a thought in my mind. I don't have an opinion either way.

Q You have referred to that developing framework, and the Inquiry

has been supplied with documents by NHS Lothian about that. I do not think we need to go through them just now.

A Okay.

Q In your view, is there anything more that needs to be done, either by health boards or for health boards, to improve their handling of capital projects of this type?

A A couple of things might occur. I've already talked about having, perhaps for everyone in the NHS, a better understanding of the accountability arrangements between NHS Assure and boards. That's a relatively simple matter, but I think in considering this matter and listening to other witnesses, the question arises in my mind about the workforce plan that we might put together on a national basis to be able to respond adequately to the NHS Assure processes. A question in my mind, particularly around infection prevention and control numbers, their training, their accreditation, and their ability to engage in a new sphere of work is something that we might consider on a national basis. Probably best done nationally because you don't run a training course for every health board.

Q Yes.

A So that would be an SG responsibility for that, and I've already

talked about perhaps proactive sharing of Assure findings in one project, and I'm sure they will do this, in terms of their applicability of those findings to other projects in Scotland.

Q In other words, learning from one project and making the lessons available to those doing projects in the future.

A Absolutely right.

Q Professor Connaghan, thank you very much. I do not have any more questions for you. It is possible that somebody else may do, so if you wait there for the time being. Thank you, my Lord.

THE CHAIR: Thank you, Mr McClelland. What I propose, Professor, is that I will ask you to return to the witness room for perhaps 10 minutes, just to check with the legal representatives in the room as to whether there is anything that they wish to be put to you. So if you go 10-- should be no more than 15 minutes.

(Short break)

THE CHAIR: Mr McClelland?

MR MCCLELLAND: Thank you, my Lord. There are no further questions for Professor Connaghan, so at least as far as I am concerned, we can proceed with Professor Fiona

McQueen.

THE CHAIR: McQueen. We will bring Professor Connaghan back in and advise him of that. We have no further questions for you, Professor Connaghan, and therefore you are free to go, but before you do, can I express my thanks for your attendance today, but also the time spent in preparing your statement. I very much appreciate this is a not inconsiderable task, and I am grateful for you having carried it out. You have provided significant assistance to the Inquiry, but you are now free to go. Thank you.

THE WITNESS: Thank you, my Lord.

THE CHAIR: So, we will now hear from Professor McQueen. Good afternoon, Professor McQueen. Now, as you understand, you are about to be asked some questions by Mr McClelland, who is sitting opposite, but, first, I understand you are prepared to take the oath?

THE WITNESS: My Lord, I am, yes. Thank you, and good afternoon to you.

Mrs Fiona McQueen

Sworn

THE CHAIR: Thank you very much, Professor. Mr McClelland?

MR MCCLELLAND: Thank you, my Lord.

THE WITNESS: My Lord, may I be so bold as to interrupt? I'm no longer a Professor, so it would be inappropriate for me to continue with that title, if you're going to call me that. So, Miss/Mrs/Fiona, or accept that I'm no longer a Professor and a slip of the tongue will go unnoticed.

THE CHAIR: Right. That shows a very proper----

THE WITNESS: Apologies.

THE CHAIR: -- a proper propriety. What are you most comfortable with?

THE WITNESS: I would be happy with Fiona, but I'm equally happy with Mrs McQueen.

THE CHAIR: Yes. Mr McClelland and I are rather formal people, so----

THE WITNESS: Mrs McQueen it is, then.

THE CHAIR: I think I can speak for Mr McClelland in that respect. Mrs McQueen. Mr McClelland?

Questioned by McClelland

Q Good afternoon, Mrs McQueen.

A Good afternoon.

Q Could I ask you just formally, please, to confirm your name?

A My name is Fiona McQueen.

Q Have you provided a witness statement to the Inquiry?

A I have.

Q If we could have up on the screen, please, the document at witness statement bundle volume 1, page 129. Do you see there on the screen your witness statement?

A I do.

Q Does that statement set out fully and truthfully your evidence on the matters that it addresses?

A It does.

Q Is there anything in it, so far as you are aware, that needs to be changed or corrected?

A Not at the moment, no.

Q Now, you were formerly the chief nursing officer in the Scottish Government. Is that correct?

A I was.

Q That was between approximately 2014 and April of 2021?

A It was.

Q You describe yourself in your statement as semi-retired, although it appears from your CV that you remain pretty active in public life.

A Indeed.

Q For example, you are the Chair of the Board of Ayrshire College.

A I am, yes.

Q And a member of the Scottish Police Authority.

A I am, that's right.

Q But now retired from your full-time medical career.

A Exactly.

Q Yes, and you are, I think, by professional qualification, a nurse.

A I am.

Q So, as we have just discussed, you were the Chief Nursing Officer for seven years or so. Could you just provide us with an overview of what that role entailed over the time that you held it?

A So, I would argue that fundamentally it's a professional leadership role and it provides professional advice to the ministerial team, so the Cabinet Secretary and their ministers. It also provides professional leadership for nurses and midwives across Scotland.

Q As the chief nursing officer, are you the head of a directorate or a department within the government?

A So, it is a directorate within the government. So, I would be a director within Scottish Government with director-level responsibilities,

reporting to the director general who was the accountable officer for health and social care, and within that directorate then, there would be Healthcare Associated Infection Policy and Antimicrobial Resistance, there would be workforce development for the professions, which would include commissioning of undergraduate nursing places, regulation of healthcare professionals, some legislation we put through, but also being a general director of the health and social care directorate.

Q Okay, and just give us a rough indication of the size of that directorate in terms of people and so on.

A So, I can't remember exactly, but-- I'm thinking around 80, but I couldn't be certain.

Q Okay. At paragraph 6 of your statement, you identify parts of the remit of that directorate, and you say that it includes:

> "…leading on… health-care science… and leading on all aspects of healthcare-associated infection policy and antimicrobial resistance."

Could you just expand a little bit on the work done in those areas when you were there?

A So, the healthcare

science is a healthcare science workforce, and that was about, essentially, leadership of the healthcare science workforce, which would be from the Chief Healthcare Science Officer, and that would be mirroring my responsibility for nurses within Scotland. Then, healthcare science is a broad church of professional groupings within the NHS, so laboratory workers, cardiac physiologists, audiologists, and they would provide leadership and policy development on that, and they operationally reported into me as a director.

The Healthcare Associated Infection Policy and Antimicrobial Resistance was a policy area within my directorate. It didn't necessarily have to be within the CNO's directorate, it could have been one of the pieces of policy that was taken by a number of directorates, but it sat with the CNO, I think particularly since Lord MacLean's public inquiry into the Vale of Leven, when it was recognised that nurses and midwives have a big responsibility in preventing hospital-acquired infection.

So in 2016, for instance, we published a strategy-- the government published a strategy on Antimicrobial Resistance and Healthcare Associated

Infection that was lasting until 2021 that had a number of key components in it where we developed policy and that then would be articulated into day-to-day practice.

Q Okay, and you said there that this was an area of work which could have been in other directorates, but happened to be located in yours. Does that reflect the fact that it goes beyond the realm of nursing and into other parts of the health service?

A Indeed. Antimicrobial Resistance is part of that, and although there's an increasing number of nurse prescribers – the bulk of prescriptions are written by medical staff – there are cleaning standards, there's the health environment inspection, and there's day-to-day clinical practice for everybody who's delivering clinical care, and therefore it does go wider, but there's a predominant, I think, role and responsibility for nurses in this area.

Q Yes, okay. Now, as I think you will probably be aware, something of interest to the Inquiry is the interaction between building engineering services such as ventilation and water and so on and infection control, and so there are obviously engineering elements to that and infection control elements to it.

When you were the chief nursing officer, to what extent was the role of building engineering services in infection control something that was on the radar screen of your directorate?

A The building engineering services and hard Facilities management services, the leadership of that was through Christine McLaughlin and Alan Morrison within government, and exercised through Health Facilities Scotland and Health Protection Scotland-- or Health Facilities Scotland in particular, but Health Facilities Scotland and Health Protection Scotland had a close working relationship within National Services Scotland. It didn't feature hugely at that time, because there were standards, Health Facilities Scotland dealt with that, and if it were determined a need to be involved in the HAIAMR strategy, as we would call it, we would have done that, but at that time there didn't appear to be a need because there were extant standards.

So, whether there were issues around water and ventilation needing an authorising engineer for that, there were standards that Health Facilities Scotland issued guidance on. Then that was taken care of there, and it tended to be more of the either soft FM or operational clinical practices that

were involved in that at that time.

Q Okay, so I have understood it, you have described there the responsibility for the policy, I suppose, or the guidelines in relation to the engineering systems sitting within Health Facilities Scotland. You mentioned Alan Morrison and Christine McLaughlin. They were – certainly, Mr Morrison still is, I think – officials within the finance part of the healthcare directorate. Is that correct?

A Yes, and similar to the CNO's responsibilities being wider than nursing, I think the finance directors' responsibilities would also be wider than finance.

Q Insofar as engineering issues were being considered in the level of the Scottish Government, does that reflect the fact that, if you are installing an engineering system, it tends to be an item of capital expenditure or money is being spent on it? Is that why it found its home there?

A I don't know, but I rather suspect so.

Q Yes. Just going slightly beyond that, not necessarily in relation to matters of detailed engineering, but on things like the output parameters of building services that bear directly on the care of patients, I have in mind

things like air changes produced by a ventilation system or pressure gradients generated by a ventilation system, to what extent was that kind of thing on your radar screen insofar as there might be a need for training or knowledge amongst healthcare staff?

A So, we did have a section within the strategy, and certainly in our day-to-day policy work there would be ongoing dialogue about, were there any inhibitors of good and effective infection control procedures. There was an assumption that that would be taken through Health Facilities Scotland.

Now, within my policy area when I was CNO, there were some areas that were arising out of the Queen Elizabeth that I think took our focus round about slightly more widely than the traditional clinical staff and clinical guidance. When Healthcare Improvement Scotland did an environment inspection within the Queen Elizabeth, it signalled cleaning of the ventilation grills but also the Healthcare Environment Inspectorate that HIS have also, at times, would signal areas there, and that would be dealt with at that time on a one-to-one basis, on a single-issue basis.

Q So, the Inquiry has heard all about SHTM 03-01 and the

parameters that it recommends as outputs for ventilation systems in different clinical environments. Was there an expectation at the time that you were the chief nursing officer that healthcare staff responsible for the care of patients would have a knowledge about things like air change rates or pressure gradients?

A Day-to-day healthcare staff, I would not have expected. So, the traditional ward sister or senior charge nurse, I would not have expected to know whether or not there were 6 air changes, 2 air changes, or 10 air changes, unless they were working in a more specialist area such as theatres or the Burns Unit or Intensive Care areas where there was a requirement for higher level, but all I would have expected of the clinicians there was to know that the engineering requirements needed to be met. That was really about access to services. So, they would understand the importance of the Facilities staff, the hospital engineers coming in, making sure there was appropriate maintenance and ongoing upkeep, rather than them having a detailed knowledge. I would have expected the hospital engineering staff to know very detailed information about what was required to keep the hospital in a fit

and proper state.

Q That knowledge of output parameters – and I accept what you are saying, that there is a limit to what you would expect from the clinical staff – was that-- or did it ever become a formal part of their training, or was it something that they would be expected to learn on the job?

A I don't think it would be part of people's training, although I understand at the moment National Education Scotland is looking at a knowledge and skills framework for the built environment which I suspect will bring in early introductory information at the early stages right through to the more expert specialist knowledge that we would require of infection control practitioners and hospital engineers. So I don't think it would be part of the training. I don't think that would be necessary, but I think an element of an understanding of it. So, when you say on the job, I feel that's too casual. I think it would be part of someone's induction and understanding of their managerial responsibilities as a senior charge nurse of understanding the environment within which they worked, the environment within which they delivered care, and that would be part of an induction programme of people moving into that area to work.

Q Yes. Thank you. Now, moving from the generalities to the specifics, the issue with the ventilation in the Critical Care Department at the RHCYP came to prominence in July 2019, and I think you say in your statement that you were on leave of absence at that particular time and came back to work in August of 2019. So by that time, much of what one might call the "initial emergency response" had already happened. So, in other words, the Cabinet Secretary had decided already to postpone the opening and the Oversight Board had already been set up. Is that right? Those things had happened by the time you came back?

A Completely.

Q Yes.

A Done and dusted.

Q Yes, and on your return you became a member of that Board, the Oversight Board, and I think you say that you became its chair from 2019-- October 2019, and you cover in your statement the fact that the Oversight Board was set up following the escalation of NHS Lothian to Stage 3 on the Scottish Government Support and Intervention Framework. Is that right?

A Yes.

Q Okay. If we just have a look at the terms of reference for the Oversight Board, these are at bundle 7, volume 2, page 354. In fact, if you just go back to 353, we can see there "Terms of Reference," and it is actually marked as a draft. The author, Christine McLaughlin, the approver, Malcolm Wright, and then if we go over the page to 354, if you just read from what it says under the heading of "Background":

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

So do you understand from that that the Oversight Board was essentially an assurance mechanism for the government?

A Indeed, I think an assurance mechanism for the government but also an assurance mechanism for NHS Lothian to provide them with the appropriate support.

Q Okay, so did you see it working both ways, essentially?

A For sure.

Q Yes, and if we read on to the fourth paragraph:

"Work has been initiated to identify the solution needed to ensure the ventilation in the critical care unit in the new site meets the required clinical and safety standards. Scottish government has commissioned NHS National Services Scotland (NSS) to undertake a detailed assessment of all building systems in the new hospital which could impact safe operation for patients and staff [and so on]."

So do we see there that there were broadly two elements to the work? First of all, the issue of a solution to the critical care ventilation issue itself, but more broadly than that, a wider assessment of the hospital's compliance with guidance?

A Yes.

Q And then reading on it says:

"This work will be phased, with assessment of water, ventilation and drainage systems prioritised, including the proposed fix for the ventilation unit."

Do you know why it was phased in that particular way?

A Risk. So the other aspects, medical gases, fire and

electricals, would have appeared less critical, but learning from the Queen Elizabeth, you don't know what you don't know. So I think, given that there had been a problem identified, it was determined important to take a more comprehensive look to check and test that everything was in order that it should be, and therefore it would have been, certainly ventilation, based on the fact that they weren't meeting standards, water based on what we knew about the Queen Elizabeth, and drains similarly.

Q Okay, thank you. Then just the final paragraph in that box:

"In order to provide co-ordinated advice to ministers, an Oversight Board is being established which will seek assurance from NHS Lothian that according to its due diligence and governance, the facility is ready to open; and from NHS NSS that its agreed diligence has been successfully completed."

So there is reference there to NHS Lothian and to NHS NSS. Were those really the two sources of information that the Oversight Board had for its decision-making?

A Yes, NSS contained Health Facilities Scotland and, at that time, Health Protection Scotland, soon

to become NHS ARHAI, and they were the expert groups available to NHS Scotland, so that was important that they were involved.

Q Yes, and then if we look at the scope of work, there is a list of bullet points about the things that the Oversight Board are going to do. So:

> "Advice on phased occupation; advice on the proposed solution for ventilation and critical care and on any other areas that require rectification works; advice on facility and operational readiness to migrate [and so on]."

And down at the bottom we see there, "Identification of areas that could be done differently in future." Now, we are sort of slightly jumping ahead to the end, but just while we are here, do you recall if that was something that the Oversight Board did or was that not done?

A I think it could have been done more comprehensively had we not had COVID. We did it on an ongoing basis, so, again, there is absolutely no point in having such a critical piece of work in terms of overseeing the safety of a capital programme for the health service if we were going to wait until the end to learn. So I think there was ongoing

learning, and as HFS and HPS and NSS were in the room, then that ongoing learning was taken away. I don't have it in front of me, but my understanding is that the last meeting of the Oversight Board had a summary of the issues that had been dealt with. I think we didn't publish a report as such from the Oversight Board, and I don't know that it was ever intended to do that. On reflection, a final report may have been helpful, but with COVID coming in and the intense pressure that the key people who were involved were under, in terms of giving professional advice and support, I think we felt it wasn't appropriate to do that.

Q Okay, and if we look over the page at the membership of the Oversight Board, we can all see the list of people, but it includes the chief finance officer, chief medical officer, chief nursing officer of the Scottish Government, officials from NHS Lothian, Scottish Futures Trust, NHS NSS, and so on. Fair to describe this as quite a high-powered body in terms of its seniority?

A I think it was a body that was appropriate, given the level of advice that was needed for the Cabinet Secretary.

Q And just to expand on

that?

A I think given we had one of our big NHS boards with a project that appeared not to meet standards, that there needed to be a confidence around that Board table of challenge and giving advice. It was deemed appropriate that it would be that senior level who would be around the table.

Q Okay, and given the seniority of the people that were there, and just having regard to the answer you gave a moment ago about no production of a formal report of learning, was there a sense in which all of these officials were able to learn on an ongoing basis and take lessons back in that sense? Was that something that was underway?

A For sure, as it was, and individuals did take that forward. I also finished my employment in April 2023--2021, so I can't speak for subsequent learning that may have taken in a more formal fashion, but one would certainly have expected the people who were around the table to take things forwards and weave them into day-to-day practice or initiate programmes of change.

Q Okay. Was that something that you yourself were able to do through your membership of the Oversight Board?

A Constantly. I think the whole issue of learning and improvement was something that is fundamental to healthcare provision and, within my policy team, they were constantly back and forwards with NHS boards, whether it was to talk about outbreaks or whether it was to talk about learning or people would look for advice for them. I did host in June 2019 certainly, learning from the Queen Elizabeth in terms of moving that forwards, but I think given the issue of COVID that came in, in the latter part of the Oversight Board work, it was difficult to have more formal learning in a comprehensive way, but I'm confident that would have been taken on by my successors.

Q Okay. Now, you explain in your statement that shortly after your arrival on the Oversight Board, NHS Lothian was escalated to Level 4 on the escalation framework, and we know that one of the key consequences of that was the appointment of Mary Morgan as the Senior Programme Director. What was the scope of Ms Morgan's role?

A She was expected to manage the whole programme and have, in my mind, full roaming rights across the programme. She developed a planned programme of

work and she was involved in making sure that the project milestones were reached, and she was particularly skilful at finding solutions to problems that may have arisen in terms of being an intermediary or identifying and bringing together the people who could resolve that problem, but she essentially reported on the outcome of the programme, made sure that the programme milestones were met, and if they weren't met, there was a cogent reason given, an explanation and an adjustment to the plan was put in place.

Q Okay, and when you referred to her having responsibility for the whole programme, do you mean by that the two things that we looked at before? So the solution to the critical care ventilation but also, more widely than that, ensuring that the rest of the hospital was brought up to the requirements of the guidance?

A Yes, because within NSS's report there were other areas that were identified that needed to be corrected, and indeed the Lochranza in terms of haemato-oncology also needed a change, but that was probably more based on anticipated needs of future patients rather than necessarily inappropriate scoping.

Q Okay, so we have all that additional work that the Health Board has got to cope with. Is it fair to say, to see the appointment of Mary Morgan as the provision of additional management resource to the Health Board to help get all of that work done, in short? Or was there another element to her role?

A I think she had two faces to her role. So her role, I would say, would be helpful to NHS Lothian because it was an additional resource and it gave an external perspective. So someone who hadn't been steeped in the whole programme and gave fresh eyes. It was someone with programme management skills who could help lift herself out of the day-to-day contract negotiations, managing people and she could take a perspective. She also gave confidence to myself as chair of the Oversight Board, Cabinet Secretary, but I think confidence to the Oversight Board that work was being kept on track and there was an on balance reasonableness if things were falling behind or things needed to be challenged. I think she was a very helpful person, and that role was important to give additional support and oversight to NHS Lothian, but also to give additional assurance to myself as Oversight Board chair, but also the

director general and the Cabinet Secretary, that work was on track.

Q Okay. Now, you say in your statement that the most intense period of activity for the Oversight Board was from your arrival in August 2019 through to the end of October 2019. What was it that made that particular period particularly intense?

A I think it was making sure that everything had been assessed appropriately, that there was a reasonable planned programme of work and then-- which could then be put in place, and once that was-- once it was agreed, what was needed to be done and taken forwards. Then having the planned programme of work and making sure it carried forward, there was less formal decisions that needed to be taken and perhaps less in the way of discussion about what should and what shouldn't be done.

Q Okay, so the intensity came from, in short, trying to work out what needed to be done----

A Yes.

Q -- and after that it was a case of making sure it was done?

A Because when the decision-- Although I was off on sick leave when-- the decision to stop the occupation of the hospital, it wasn't

done thinking, "We'll delay the move for two years." It was done thinking, "We'll delay the move hopefully for a few weeks or a month or two," to determine what additional work needed to be done. I don't think it was expected that there would be such a comprehensive programme of work in that, so it was important the clinicians and all of the staff had had their rosters made up. Some new staff had been recruited based on where they would be working. Childcare arrangements had been made and all of that needed to be unmade for staff, and patients were looking forward to improved facilities. Therefore, I think it was reasonable that as much urgency could be put into determining what was going to happen so that we knew how long we would need to take. I mean, clearly COVID got in the way of that, but it was important that we did all of that work so that we could determine what needed to be done and how it was going to be done.

Q Okay. Now, on the critical care ventilation itself, the remedial works which were instructed were for the achievement of 10 air changes per hour and 10 pascals of positive pressure. Was the choice of those particular parameters something that was discussed by the Oversight

Board at all?

A That would have been outwith our area of expertise. The choice of meeting standards, I think, was that of Health Facilities Scotland, Health Protection Scotland, so looking at the guidance. I think also working closely with the senior infection control doctor and senior infection control nurse of NHS Lothian to make sure that everyone was satisfied that the standards that were coming and going to be put in place were there, and once the Oversight Board was satisfied that those agencies – so HFS, HPS and internally the infection prevention and control team – were satisfied, then we were satisfied.

Q Okay. So, just to be clear about it, the choice of these parameters was being discussed and decided upon by others outside of the Oversight Board?

A By experts outside. Well, also coming in attendance to the Oversight Board in terms of HPS and HFS, because there are national bodies that exist to provide professional expertise and guidance, and therefore it was appropriate that we took that expertise and guidance.

Q Okay, and if we go, please, to bundle 13, volume 4, at page 704, you should, I hope, see in

front of you there the minutes of the Oversight Board on 22 August 2019. Do you see that?

A 22 August, yes.

Q 22 August 2019. I think you are marked as present. I think this is probably your first Oversight Board meeting, and if we just look down to 4.2.5, please, we see there recorded:

> "The Oversight Board agreed that it was now content with the critical care specification specification and that it clearly outlined which areas within the building this agreement applied to."

So, we see there quite early on in the life of the Oversight Board the specification for the critical care ventilation was accepted. Was that a reference to the 10 air changes and 10 pascals of positive pressure?

A Yes, and that was the critical care specifications explicitly.

Q Okay, and then if we go down to 4.2.7, what it says there is:

> "It was noted from discussion last week it was very clear that it would not be possible to secure a fast tracked technical design unless [NHS Lothian] agreed to waive the right of a legal challenge for the current design of the critical care system;

this was coming from Multiplex, not IHSL."

So, is it fair to say that insofar as there were obstacles to progress, it was not the choice of the technical solution, but rather the commercial implications of it?

A Yes.

Q Now, we understand from other evidence that the choice of those particular parameters of 10 air changes per hour and 10 pascals of pressure was perhaps not entirely straightforward. The designers, as you may know, held the view then and continue to hold it now that the critical care ventilation that they designed at four air changes per hour and with balanced pressure was compliant with guidance. Were you aware of that when you were on the Oversight Board?

A I was aware that there was a mixed view of what was appropriate, and I was aware that the designers and builders believed that they had designed and built a hospital that was both meeting the standards and, in particular, was that specified by NHS Lothian. However, I think when you build a hospital – or have a big refurbishment, but in this case building a hospital – what you have to do is have a strategic intent about what the

building's going to be used for.

So the building was going to be used for our very sickest children in the east of Scotland. From a life cycle point of view, we would hope it would be in existence for 25 years or, if you look at the previous Sick Kids, even longer; and therefore it's important to understand, if we look at the technological advances that have happened that mean clinicians can treat the very sickest children in a way that perhaps 10 years ago we would never have dreamed of, I believe we have to have the most up-to-date, on balance, best guidance you can have put into your hospital, without worrying about profit, without worrying about whether or not there is a lower level that one could argue, if one wanted to, meets the guidance.

Q Okay. It is helpful to have that evidence. Was that something that was in your mind at the time, or was the Oversight Board just proceeding on the basis that it was going to be 10 and 10, and, "Let's get on with it"?

A In my mind, that was the best guidance available, and whilst there may have been arguments to have a lesser option then, I didn't understand why we would not want to have the very best we could for the

safety of patients and for staff as well.

Q We understand that there may have been some debate, or at least concern, at one point amongst the critical care clinicians about the suitability of a positive pressure arrangement for their clinical needs. Is that something that you were aware of at the time?

A I think Alex McMahon and Tracey Gillies both kept the Oversight Board up to date with clinicians' views. I can't remember if that was an explicit concern that was expressed, but that, I think, is why it was so important that the lead infection control doctor and the lead infection control nurse who on a-- not quite day-to-day basis, but on a regular basis, would interact with such clinicians so that they could take that overall consideration to the discussions that we were having, or HFS, HPS, the executives, Executive Steering Group were having about what standards we should have.

I think it's important to remember and understand the strategic intent of the building, and it can't always be built for one particular reason. There has to be a broader perspective taken on it. That's why it was important to have ICN, ICD, infection control nurse and doctor, contributing alongside HFS

and HPS alongside the executive at the Executive Steering Group, who could then advise the Oversight Board.

Q Yes. At a particular stage previously to the agreement of Settlement Agreement 1, there had been risk assessments involving the critical care clinicians, the result of which was a decision that a balanced or negative pressure arrangement was very important for their clinical needs, but the guidance requires or recommends a positive pressure arrangement in critical care. Was that a debate which was had at the level of the Oversight Board or had the decision about the best way to proceed been taken elsewhere?

A The advice about the best way to proceed would have been taken elsewhere, but what I, as chair of the Oversight Board, required was an understanding that there had been full support for any decision that was given to the Oversight Board. So I would not have expected a recommendation come to the Oversight Board that had a split view.

Q Okay. If we go, please, to bundle 13, volume 4, page 711, which is the minutes of the Oversight Board on 29 August 2019, we can see that you were present by telephone on that occasion; and if we go, please, to

page 713, under the heading of "Ventilation Specific Points" it says:

> "Literature review now complete - demonstrated limited and sub optimal evidence around air changes and clinical outcomes. Most evidence had been expert opinion, modelling and outbreak reports."

Then just reading on down at paragraph 4, it says:

> "Air changes is not a specific hurdle to get over but is the level generally found to be suitable in the majority of developed countries."

And 5:

> "Buildings over the last few years are much more air tight than they used to be, 4 or 6 air changes per hour is not a lot of ventilation versus an old style 'leaky' building. Air changes are covered by guidance not standards [and so on]."

Was this a discussion around the question of whether there should be four or six air changes in the general wards rather than in the specialist areas like critical care?

A I don't remember the detail of that discussion, but by looking at the notes, I think it was.

Q Okay, and the first point there is – and I think this has its origins in the NSS report – that there was limited and suboptimal evidence around air changes and clinical outcomes. Was that something that was the subject of discussion before the Oversight Board or not?

A I think I would go back to my point about what the guidance says, and it is a higher level because it's clearly more expensive. The air handling units are more complex, they require more upkeep, and therefore the argument-- I don't understand why there would be an argument to have less air changes than what was being recommended, so that we could have the safest possible environment for our patients. So I think anything was about either justifying why there had been a lower level put in or exploring, if you could keep that lower level in, it would be less costly, and also entrance to the hospital, which I think would not be an unreasonable desire, would have been quicker, rather than having to do a complete reorder of new air handling units.

Q Okay. Then if you go, please, to page 716 in that bundle. This is the minutes of the Oversight Board, 5 September 2019, and then item 2.1, there is a heading, "Haematology-Oncology Requirements

Key Points", paragraph number 1:

> "Opportunity now being taken to bring all 12 single rooms (in addition to the 5 isolation) up to the required standard for neutropenic patients."

Then at point 3:

> "Scope of work is similar to that [undertaken] with the critical care board change."

What was your understanding of the issue there and the decisions taken upon it?

A So, learning from the Queen Elizabeth where there had been concern about outbreaks, had been concern about the environment that the children were being cared in, I think you'll see-- I think it was probably three minutes ago, you drew me to, I think, 4.2.5, but I noticed that 4.2.4 was where I first had raised the issue about haemato-oncology and what air changes did we have there?

So, the issue was about-- And there's always a risk when you stop a building programme, that everyone wants to get their improvements in, which can be more costly and can take a long time. So you do have to guard against it and have a very firm change programme in place.

However, I did take the opportunity to ask about haemato-oncology. The executive team took that away and had a reflection and a discussion on it, and given what I'd said about this building was going to be in place for at least 25 years, an opportunity to, I think, increase the specification so that every room would be at that. It would give more flexibility for individual patients, but it would also mean if there were changes in technology and medicine, that we may see a different client group who needed a different environment to work in.

So, there were a number of times when we said, "On balance, we're going to stop anyway. Will we add this in?" And sometimes it was no, and sometimes it was yes, and in this case, it was yes. We believed it was right for the haemato-oncology ward to have an increase in specification.

Q Was that seen as an improvement to the hospital rather than a piece of remedial work in the way that the Critical Care Department was seen?

A That's exactly what it was. There were a number of areas where there was improvements that we took the opportunity to do, which I've already said sometimes is a risk, but that was not about poor specification or poor billing.

Q There is a-- I am trying to do this from memory, so I hope I am correct, but there is a line in the table of guidance at the back of SHTM 03-01, and it deals with, I think it is neutropenic areas or something like that.

A Yes.

Q It recommends the 10 air changes and 10 pascals of pressure. Having regard to the existence of that line in the guidance, why is it that the work to the haemato-oncology department was regarded as an improvement rather than a piece of remedial work?

A So, from the minute – I couldn't have remembered from memory – there were the five isolation rooms, and one would normally-- well, you would isolate a neutropenic patient. NHS Lothian would have made the calculation based on current patient population with perhaps a slight increase because, increasingly, there's improvement-- improved outcomes for children. We're treating children that we wouldn't have treated before, and they have excellent survival rates, but they do need to be nursed in isolation. So, they would have calculated five would have been sufficient, and I don't think the Oversight Board-- and I certainly wasn't saying I thought five was insufficient. It was more, given the Queen Elizabeth were going to upgrade their whole unit to that, would it not be helpful for future-proofing the building and providing the safest possible environment for our children that we upgraded that? The executive took that away, they had a discussion, they must have looked at numbers and had an additional reflection and decided that they would upgrade the whole unit.

Q Okay. So, in short, an improvement based upon extra information, or perhaps renewed thinking, that would not have been available to the NHS people at the time the different specification was chosen?

A Indeed. One could say it was opportunistic, but I think also based on learning from the Queen Elizabeth, it was thought to be an appropriate way forwards.

Q All right, just bear with me, Mrs McQueen. Yes, if we go, please to page 759 in that bundle, which is the Oversight Board minute for 5 December 2019, and if we go over the page to item 5, we see there:

> "High Value Change 107 – Ventilation Works to Paediatric Critical Care and Haematology/Oncology. The

> Oversight Board approved the High Value Change combining the Paediatric Critical Care and Haematology/Oncology ventilation works into a single High Value Change [and so on]."

Then it reads:

> "It was noted that the first technical workshop in relation to this work would be held on Tuesday 10 December 2019."

That reference there to a technical workshop, was that for the development of the detailed design to achieve the desired output parameters?

A So, there were technical workshops, I think for two reasons; one where people actually couldn't agree, and I wasn't prepared to compromise. I needed to make sure, and be assured, that everyone involved – certainly from the Infection Control team in Lothian and HPS and HFS – were satisfied that they were recommending to the Oversight Board-- what they were recommending to the Oversight Board was appropriate and safe. At times, yes, there may have been-- And so that would be one reason, and then the other reason would be looking at the technical specification where you have choices with air handling units, you have

choices about-- not refurbishment, about ongoing maintenance, you have choices about how things will work, and that would have likely have been that rather than trying to find an agreed solution.

Q Okay, and then if we just go forward, please, to page 773, which is the Oversight Board minute for 29 January 2020. If we scroll down, at the bottom, we will see a heading, "3. Senior Programme Director's Report. Then over the page, the third bullet reads:

> "Noted that engagement to reach final design was key to the ventilation works. Engagement taking place on a weekly basis, involving highly technical discussion. The Settlement Agreement cannot be completed until the design is signed off. Costs remain to be assessed [and so on]."

So, on the reference there to "highly technical discussion," were there challenges in the design?

A I think when you start from scratch, and you have an open piece of land and you're going to build your building, your hospital, then the design that you have is optimal for the – if it's a hospital – patient needs, and for the way the building flows, and for

the M&E services that you have within a hospital. When you're retrofitting, it becomes much more complex because there are interdependencies of systems, whether it's electrical, whether it's pressure, and therefore it is not-- it's not easy and it's not straightforward. Albeit this was a hospital that hadn't been occupied, it did have existing mechanical and engineering systems and structures in place. So to get something that was appropriate, that was going to be safe, effective, and mindful of the public purse, be as cost-effective as possible but also have ease of access for ongoing maintenance and for cleaning, because that is also an issue.

I can't recall how this was designed but if the engineers can access the air handling units for ongoing maintenance without disturbing patient care, that is ideal but, sometimes, the way it's been built means it's straddling, say, two rooms and that would then mean there'd be two rooms out of place, or the access has to be from within the ward, which again causes additional risk. So there are many factors. It is so much simpler to put in a ventilation system from scratch and from new, rather than have to retrofit that.

Q Yes. So, in other words, technical difficulties because this was a change being made to a building which had already been built?

A Exactly.

Q If we go forward, please, to page 776, which is the Oversight Board minute for 20 February 2020. At 2.1, there is a heading about ventilation or management requirements for source isolation, and just the second round bullet there reads:

> "Noted that five isolation rooms in Critical Care currently supply the correct number of air changes, all from the same air handling unit. Work underway to reduce the dependency of all five rooms on the single air handling unit."

What, so far as you can recall, was the resolution to that problem?

A I'm sorry, sir, I don't remember the resolution to the problem.

Q Okay, that's fine. As we are always keen to say, it is not a memory test, so if you do not remember, do not worry. All right. Settlement Agreement 2 came to be agreed between NHS Lothian and IHSL, and that was essentially the contractual basis for the remedial works. You explain in your statement

that there were complexities in relation to the negotiations around that, and as I read it, you explain that there were two categories of complexity. First of all, in the works themselves, and I think we have covered that, the reason for that, but, secondly, the existing contractual arrangements in which all of this had to be done. Can you explain what your understanding was of the difficulties that arose in that context?

A The contract negotiations were a matter for NHS Lothian, so we didn't have a huge amount of detail at the Oversight Board because it was clearly commercial in confidence, and the accountability remained with NHS Lothian. I think the difficulties were around responsibility of who should have provided what, and who should have said what, when. I think there were-- it was a delicate balance that the funders needed to be approached for funding. There needed to be, as far as possible, the guarantee that the contractors would have put in place for M&E services, would continue.

So there was a risk that if there was a particular approach was taken, that the original SPV wouldn't guarantee the work, and that could have been very, very expensive and costly for NHS Lothian. So there was

a delicate balance and I think that sometimes it meant issues took longer than we would have wanted, but it took the time it took to get to resolution. So, it was about making sure the funders were still fully involved and wanting to provide the funding; it was about securing best value, in terms of not having to spend an inordinate amount of public money on changes; and it was about making sure that the SPV would still hold the risk of any ongoing guarantee, or maintenance of the M&E systems that were being put in place.

Q Is there perhaps a parallel here with trying to do works to a building after it has been built that contractually trying to renegotiate things, after all these complicated contracts have been put in place, is inevitably going to be a challenge? Would that be fair?

A I think you're right. I think in particular because NHS Lothian had accepted the building and was paying money every month for the building. I think that's a good way of summarising it.

Q In the particular context of an NPD or PFI project, you have got a lot of people involved. So you have got the project company, the building contractor, the designers, the funders

and so on. Was it your understanding that just trying to get all of these people to agree was a challenging thing to do?

A So, it was always going to be challenging. It was complex and, particularly, I would have said NHS Lothian were on the back foot because it'd already taken over the building, this was a change that we kept moving forward in the change mechanism, so that was always going to be tricky.

Q You say in your statement that you were frustrated that the negotiations were not more straightforward. Did you think that there was anything more that could have been done to move that along?

A No, I think it was what it was, and I believe the NHS Lothian team worked as hard as they possibly could to try and find a resolution, but they were cognisant of the fact that there were complexities.

Q Now, you explain in your statement that migration of services to the new hospital and patients to the new hospital took place in phases. In broad overview, what approach did the Oversight Board take to its decisions about the phasing of the migration?

A There was a desire to have the hospital building occupied as soon as possible for some of the

reasons I've alluded to. Staff were employed to work at the new site and therefore had extraordinary travel times if they were going to the old sites. Childcare arrangements had been put in place. The new building was there. Once it was fit for purpose, it was a much-improved environment for people to have, and NHS Lothian were paying for it. So, there was a desire to have the building occupied as soon as it possibly could be, but making sure that the hospital was as safe as it possibly could be at the same time.

We were in the hands of the NHS Lothian executive team, so we talked about moving in phases, and for some services that was deemed appropriate but for others, particularly when clinicians were involved in, say, outpatients as well as inpatients, it would have meant too much-- loss of clinical time and therefore would have been inappropriate. For instance, CAMHS moving, they didn't want to be housed in an isolated building without a lot of other people around, so these things had to be taken into account.

For DCN, for instance, once we had COVID, the burden of work for anaesthetists changed quite significantly, and therefore that probably hastened the move over to

the Royal Infirmary site, so that the anaesthetists could have a more compact area for them to work in, but we very much were guide given. I think we all wanted, in the Oversight Board, to move in as quickly as possible, as safely as possible, but we were guided by NHS Lothian. We had a member of the Area Partnership Forum as part of the Oversight Group, who was essentially a staff representative. So we were cognisant of the needs of staff as well as patients, moving forwards.

Q Okay. Were considerations slightly different for the Department of Clinical Neurosciences?

A So, it wasn't necessarily as straightforward. They were in an environment where they had water challenges in terms of pseudomonas. The imaging kit----

Q Sorry, this is at the Western General?

A For the Western General, yes.

Q Right.

A In terms of the old site, was less than ideal, but that's why you pay a lot of money to move into a new hospital when you need to change the current site. So, there were issues with water, there was issues with the imaging kit that they would use. Now, one of the resolutions was to buy a new scanner and put that in place, which would reduce the risk of the scanner breaking down. We did have confidence in the infection prevention and control systems and processes in terms of managing the risk with water, but through choice that would have been the first area to move because it was the area that needed a new building most out of the three, I would say. Then, when COVID came, it slightly changed the balance.

Q Just explain how it was that COVID changed the balance.

A So, COVID changed the balance on a number of areas. First of all, Infection Prevention and Control teams, Health Facilities Scotland, and Health Protection Scotland were all hands to the pump in terms of providing advice to the service, whether nationally or individually. The anaesthetists were heavily needed for the general Intensive Care Unit for intensive care patients because of COVID as well, so therefore asking them, they were moving towards the Royal Infirmary in terms of the work for ventilating COVID patients.

At times, they would also be needed for ventilation of the neurosurgery and neurology patients, so it was more appropriate that they

moved. We took advice from the executive medical director on that move sooner rather than later, where there may have been the-- I think the clinicians may have been more thoughtful about moving without COVID in terms of wanting to take a more measured approach, but actually it happened more quickly than we had anticipated because of COVID.

Q Okay. So, that is perhaps a rare example of something happening more quickly because of COVID.

A Indeed.

Q Everybody here will recall disruptions caused by COVID. Did COVID also have an impact the other way? Did it make the migration or the move to other parts take longer to achieve in any sense?

A So, COVID and Brexit, but COVID, yes, did. Hospital buildings were assessed as government as being essential. So work wasn't stopped on hospital buildings in terms of construction the way it would on other construction programmes across the country, but we needed to put in social distancing for staff, we needed to make sure the trades workforce were kept as safe as they possibly could, although sometimes that just wasn't possible in

terms of how they work, if you needed to have two of the trades workforce working up closely. There was some COVID infections within the workforce, unfortunately, which delayed the work, but clearly the safety and well-being of the staff, the trade staff, was paramount.

It also delayed production of equipment, kit. So, you know, that happened. So, that delayed things. So, supply of products was delayed by COVID. It was delayed by having different work processes for the trades workforce, and I think the fact that the Infection Prevention and Control workforce were then focused on care delivery probably didn't hold production up because the other things were anyway, but they also needed to be diverted to providing advice for the patients and staff within the hospitals who were being (inaudible).

Q That is maybe just an impressionistic matter, and if it is impossible to say, then please just say so, but do you have a feel or an impression for how much of a delay was caused by COVID and Brexit and these sort of supervening events compared to what would have been the case without them?

A I think a number of months.

Q Okay. If we go, please, to bundle 13, volume 4, at page 827. This is the Oversight Board minute for 25 February 2021. Now, I see from the list you are not named, neither in attendance nor in the apologies. Would that have been an oversight, do you think? Do you recall if you were there or if you were not?

A I have absolutely no reason why I wouldn't have been there, and if I hadn't been there, I would have put apologies in. So----

Q Okay. Well, if we go over to page 828, we have the summary of the senior programme director's report. The second bullet, it says:

> "Noted that the programme status overall was at green with works at practical completion, with all internal building works complete."

Then, reading down below:

> "Noted that all construction validation had been submitted and there remained some HEPA filters to be fitted and tested in main single rooms, not in Lochranza Ward or Critical Care as these others had passed.
>
> The Final IOM Report was now awaited as this was the critical piece that was required to allow Infection Prevention and Control to sign off HAI-SCRIBE 4 and would then allow the Independent Tester to certify the final works so that the final service moves to the new Hospital could take place.
>
> The Oversight Board noted that the draft IOM report was expected by the end of this week… and the final report would then be completed over the next week. From the data submitted and shared there were no indications to expect any serious concerns being raised in the IOM report that would impact on final sign offs."

And then just right down at the bottom of the page, we have the word "the", and then if we go over the page:

> "The IOM report remained the important piece that was missing to allow Independent Tester sign off."

Now, all of those documents are referred to there as being needed for sign-off. Were all of those in due course received?

A Yes.

Q And then, if we go down to page 829, please. If we scroll down to the second last paragraph, it reads there:

> "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. To delay the final service moves further when no issues relating to the ventilation piece had been identified would be very risk adverse."

Now, Ms Morgan's description there of the building, to what extent was that view accepted and shared by the Oversight Board?

A So, once people enter a hospital, then you add additional risk, and that's why you have to have good risk management systems. In this case, if we're talking about-- clearly it's wider than that, but infection prevention and control, good infection prevention and control procedures, including surveillance, so that you know and understand what's happening within the hospital.

I think it was on the whole accepted. We had been thorough. The hospital had been inspected many times. We had specified the level, up to the level of the guidance, and therefore we believed that it was one of the safest and best buildings in the whole of Scotland, given its newness and its completeness.

Q If we could go, please, to your witness statement, so that is witness statement bundle 1 at page 142. It is paragraph 53 of your statement, and you are setting out here your reflections on the project, and just picking up from the second sentence, you say:

> "On reflection, I consider there could have been a sharper focus from NHSL to move forwards and to find solutions. It is easy with hindsight to say this because they were, of course, accountable for what had happened. There was an element of thoughtfulness from NHSL in that they had made a mistake already and therefore considered how they were going to make sure they could get the best possible solution out of this. When the new Chief Executive and Chair were appointed, processes improved and pace increased."

Could I ask you, what do you mean when you say that there was an element of thoughtfulness from NHSL?

A I think, understandably, NHS Lothian were not wanting to make further mistakes, and although the Oversight Board was there to support and I think therefore take some of the responsibility from NHS Lothian, the reality is, NHS Lothian were needing to make that decision and they were accountable. So, the level of accountability from the chief executive to the Board was in place.

So, I think any hesitation and anxiety about risk was based reasonably on the fact that already there had been a delay in the hospital, already there had been money paid, and already there had been arguably substandard work put in place. Therefore, there was a keenness to make sure that we moved forwards and we got this right, but I think it was probably an inevitable wounding of the team, because they recognised there had been mistakes and they recognised they wanted very much to move forwards.

Q Okay. It sounds from what you are saying that this was a sort of well-motivated attitude. In other words, trying to do the best.

A There was no

recalcitrance. It was absolutely wanting to do the best and working towards getting that very safe environment for patients, and that's what it was. It was, I think, human factors and human nature of anxiety based on previous anxieties, based on previous mistakes, making sure we weren't going to do that going forwards.

Q Yes. You explain that the processes improved and the pace increased when the new Chair and chief executive were appointed. When was that in----

A Quite near the end. I can't remember, I'm sorry. It was quite near the end.

Q Okay. Perhaps, sort of mid-2000s, something like that? Or later than that, perhaps?

A Maybe the autumn, but I couldn't say. Apologies.

Q Can I just check what you mean? Do you mean that the new chair and chief executive caused that improvement, or was it simply that their arrival coincided with the time when things got better?

A So, I don't know, but you'll note from the last minute of the meeting that the chief executive was present. I know that the chair actively sought me out to meet with me so that

they could make sure that they were doing everything they possibly could. So, whether it was coincidence or whether it was a sharper focus and they were paying attention to it and didn't-- They embraced the government support, I think, rather than resented it.

Q Was there a sense that the government support had been resented under the previous office holders?

A So, I don't know, but I think it's always difficult. Nobody really likes to be escalated, in any part of the framework – in particular not to Level 4 – and nobody really likes having an Oversight Board within their system. So, the new chief executive and chair were new, coming with fresh eyes, and they just wanted to help get the job done.

Q Okay. Is it possible that by the time they arrived, all the difficult choices and the heavy lifting had been done?

A Very much so, and it may well have happened without their arrival.

Q And in your statement, you say that the Scottish Government's interventions, so escalation, appointment of the Oversight Board and the appointment

of Mary Morgan, in your view, all of those steps were necessary. Is that right?

A Yes, because as we've already talked about the anxieties that NHS Lothian had, so there was something about providing assurance to the Cabinet Secretary and to the director general that appropriate decisions would be taken that were measured and that were time-bound, ideally, and that it would be to the appropriate standard. Therefore, having that focus, having that ability to bring in the external support and making sure there was the attention spent on it, I believe was appropriate and supported NHS Lothian to get to the position they were in.

Q Yes. Is there a case for saying that health boards doing major building projects should be given additional resource, not perhaps of the sort of scale and seniority of the membership of the Oversight Board, but perhaps along the lines of an extra project director like Mary Morgan or something like that, not after things go wrong, but at the outset of big construction projects?

A NHS boards have choices, and it's for them to determine, when they have a capital programme, what level of support that they have

and to put in place. So they make decisions about the programme team, who should be on it, what skills they have and how to take it forwards and, therefore, I would expect an NHS board who had a big capital build to have a good programme. They probably did have a programme director, but to have the resources they needed to make the programme work. I think NSS(sic) Assure will be helpful as well in terms of reminding boards of the standards that are required and making sure if there is any derogation that it is wholly appropriate rather than through personal choice.

Q You mentioned NHS Assure there. From your perspective of having held the office of a senior official in the government and from working on this Oversight Board, do you think that the NHS Assure solution is the right one and is enough, or are there other things that you think can and should be done differently for health boards building major hospitals?

A So I'm old enough to remember the common services agency building services division, and that was very helpful in terms of having an expertise grouped in one area and who would be overseeing what was

happening across Scotland. They were there for advice, they were there for guidance and an element of assurance in terms of making sure that the programmes fitted what was happening.

When we had the dialogue about, should they be in charge of all capital programmes or should that be left to NHS boards, in their current form, then NHS boards have-- are accountable for what's happening within that programme, and I would imagine, because I've not been in position now for some time, that part of the assurance that an NHS board would want to have before they signed off any programme was that NHS Assure was content with the programme of work and, similarly, HFS and NHS ARHAI, so that all standards were taken into place and there was no opportunity for derogation without good reason.

Q So, are you of the view that responsibility for projects of that nature should still remain with the health boards themselves?

A Yes, but it is a challenge, particularly for not just big, very small health boards. In big health boards, capital programmes do not come around frequently, although there's perhaps more big refurbishments than

there are of new build. So I think you have to have the balance, and health systems are regularly used to applying guidance that's not within their piece. So clinicians, for instance, will use SIGN guidelines or NICE guidelines or Royal College guidelines because it's best practice. They don't have to be instructed to do it. There's not the regulation. So it's entirely possible to have an expert body providing advice, but what I would expect is that NHS boards take them, take that advice, look at what is best practice and apply that to their building programme.

Q Ms McQueen, thank you very much. You have answered all of my questions. It is possible that Lord Brodie or some others will have questions for you. Please stay where you are for the moment.

A Thank you.

Questioned by the Chair

Q Really just a matter of detail, Ms McQueen. Quite early in your evidence, you were asked about training of infection prevention and control staff in the built environment. Do you recollect that? Now, you gave an answer, which – it is my fault – I just did not note quickly enough. Did you make a reference to a current

study or a current programme or a current project in relation to that, or did I pick you up wrongly?

A No, my Lord, you did-- I was bold enough to make reference to something that happened more recently rather than within my tenure as CNO, and National Education Scotland are currently developing, I understand, a knowledge and skills framework for the built environment for infection control practitioners.

Q Right, and that is National Education Scotland?

A NHS National Education Scotland, yes.

Q Yes. Well, as Mr McClelland indicated, we need to give an opportunity to everybody in the room to move forward the proposal that there be further questioning. So could I ask you to return to the witness room for perhaps no more than 10 minutes so that Mr McClelland can check what the position is?

A Certainly, my Lord. Thank you very much, Mr McClelland. Thank you.

(Short break)

THE CHAIR: Mr McClelland.

MR MCCLELLAND: Thank you, my Lord. With the input of core

participants, there is one further question, which I am content to ask.

THE CHAIR: I understand there is one further question there you are going to be asked. Mr McClelland.

MR MCCLELLAND: Thank you, my Lord. Yes, just one question. We discussed earlier on this afternoon the matter of moving NHS Lothian's services to the new site, and in particular we discussed the matter of the Department of Clinical Neurosciences. What was your understanding of NHS Lothian's desire in that regard in relation to the movement of services to the DCN?

A So, my understanding of NHS Lothian would be that they would have wanted to move all the services as quickly as possible, and DCN would have been one of the areas they would have wanted to move sooner rather than later.

Q And so far as you were aware, were there any different considerations from NHS Lothian's point of view in relation to the DCN?

A By different considerations----

Q Was their desire to move that particular part of their service stronger or in any way different from the other services, so far as you knew?

A So far as I knew, because of the issues around the dilapidated state of the building and the risk with water and the risk until we paid for a new scanner to go in, it would have been better for the DCN to move sooner rather than later to the new building, and we knew that, but we wanted, as an Oversight Board, to take things in due course. So it was known to us that they wanted to, but there was never, as far as I recall, a paper presented to the Oversight Board that said, "We want to move now," because clearly the executive nurse and medical director were members of the Oversight Board. So they weren't just in attendance, they were members of the Oversight Board. So at any time a paper could have come to say that we wanted to do that. I think they understood and recognised the work that needed to be done and were respectful of that, and obviously the Oversight Board was also respectful of the fact that we wanted to move DCN as soon as proper. I don't think any of us wanted to keep DCN in the Western Infirmary.

Q Okay. You really have answered all my questions now. Thank you very much.

THE WITNESS: Thank you very much indeed, Mr McClelland.

THE CHAIR: Thank you, Ms McQueen. You are now free to go, but before you do go, can I just express my thanks for your attendance today, but also the work that is involved in preparing a witness statement. I appreciate that is quite a lot of work, but thank you very much indeed, and you are free to go.

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

THE CHAIR: Now, Mr McClelland, we had hoped to get to Ms Morgan today. What is your position on that?

MR MCCLELLAND: Yes, indeed. I do not have an enormous amount of questioning for Ms Morgan, and certainly my own view, for what it is worth, is that we could get her underway and, depending on how things go, we might even manage to get her finished today if your Lordship is content to proceed that way.

THE CHAIR: Well, I would be content to follow that plan, so we will certainly begin Ms Morgan's. Good afternoon, Ms Morgan. Now, as you understand, you are about to be asked questions by Mr McClelland, who is sitting opposite, but, first of all, I understand you are willing to make an affirmation.

THE WITNESS: I am, yes.

Ms Mary Morgan
Affirmed

THE CHAIR: Thank you, Ms Morgan. Mr McClelland.

Questioned by Mr McClelland

Q Thank you, my Lord. Good afternoon.

A Hello.

Q Could I ask you, please, just to confirm your name?

A My name is Mary Morgan.

Q And have you provided a witness statement to the Inquiry?

A I have, yes.

Q Can we have on screen, please, witness bundle volume 1 at page 314? And I hope you should be able to see in front of you there, a witness statement on the screen. Do you see that?

A Yes, I can.

Q And is that your witness statement?

A It is, yes.

Q And does that statement set out fully and truthfully your evidence on the matters that it addresses?

A Yes.

Q And is there anything in it that you think needs to be changed or corrected?

A Not to my knowledge, no.

Q Now, you are currently the chief executive of NHS National Services Scotland. Is that correct?

A Yes.

Q And you were appointed to that post on 1 April 2021?

A Yes.

Q And immediately prior to that, and in fact I think the appointments may have overlapped, you served as the senior programme director for the RHCYP DCN project.

A I did. I was the director of strategy, performance and service transformation at NSS immediately prior to being appointed as the chief executive of NSS, and I undertook the senior programme director role from within that role.

Q Yes. So, your role as a senior programme director was essentially a secondment over from NSS.

A Yes.

Q So, just to be clear, you continued to be employed by NSS throughout that appointment?

A Yes.

Q You have set out your qualifications and experience in your statement, and just by way of summary, you have worked in the NHS in one role or another since 1985. Is that right?

A I started as a student nurse employed by the NHS in 1982.

Q In 1982?

A Yes.

Q Okay, and as you say, originally you worked as a nurse?

A Yes.

Q And then as you set out in your statement, you moved up through nursing management into general management at regional health boards?

A Yes.

Q And then in September 2008, you moved to NHS NSS as the director of Health Protection Scotland?

A Yes.

Q And you worked there for four years?

A Yes.

Q And just briefly, what is the function of Health Protection Scotland?

A It was really to protect the health of the people of Scotland through a variety of six functions; to manage outbreaks and incidents; to investigate outbreaks and incidents; and it also had an infection prevention and control team.

Q Okay, and then from 2012–2018, you were the director of the Scottish National Blood Transfusion Service.

A Yes.

Q And then in 2018, you were appointed as the director, as you say, of strategy, performance and service transformation at NSS.

A That's correct.

Q And just in broad terms, what was your remit in that role?

A It was mainly to lead transformation and change programmes, and I was SRO for a number of national programmes – radiology, laboratories and the suchlike – and also to look after the corporate responsibilities, the corporate role of governance for NSS.

Q Okay, and you referred there-- I think the phrase you used was "transformation and change programmes".

A Yes.

Q Just in broad terms, what does that involve?

A Bringing together everybody, all the stakeholders who have an interest in change, and coming up with the solutions that will meet the needs of the service provision for the people of Scotland, or, if it is an internal change programme, how we can improve our service delivery and take our staff with us through those programmes.

Q Okay, so those are programmes for changing the way in which services are delivered?

A Yes.

Q Yes, okay, and I think you also mentioned that you had done work in relation to corporate governance at NSS.

A Yes, that's correct. It was mainly running committee services and ensuring that the Board and committees were serviced with assurance documents and assurance processes.

Q Okay. As a means of underlying or supporting their decision-making?

A Yes.

Q All right. If we turn, then, to your appointment as the senior programme director in relation to the RHCYP, you explain in your statement the circumstances of that appointment, and just to put this in context for your evidence, by the time that you were appointed, various things had already happened, being the Cabinet Secretary had already decided that the opening of the new hospital should be postponed. Is that right, you were appointed after that happened?

A Yes.

Q And NHS Lothian had been escalated to Level 3 on the Scottish Government's performance framework and the Oversight Board had been established. Was it the role of the Oversight Board to obtain and provide to the government assurance that the new hospital was ready to open?

A Yes.

Q If we look briefly at your letter of appointment, which is bundle 13, volume 3 at page 704. I am just going to read parts of it. It is dated 23 September 2019 and it is from Christine McLaughlin in the Health Finance Directorate. She says:

"Dear Mary, thank you for agreeing to accept the role of Senior Programme Director …

This appointment forms part of the tailored support to NHS Lothian as part of the escalation to Level 4 of the performance framework for this programme, to strengthen the management and assurance arrangements for completing all of the outstanding works necessary to open the facility. The appointment formally commenced on … 16 September [and so on].

In your role as Senior Programme Director, you will have responsibility for the actions to ensure that the facility is fit for occupation, and I expect you to work as part of the NHS Lothian team. All other actions relating to the existing site and to the service migration to the new facility will remain the direct responsibility of NHS Lothian."

And was that in fact the way that your role played out in practice after your appointment?

A Yes.

Q If we look at the letter advising NHS Lothian of your appointment, which is at page 702 in that bundle, I am just going to read from the first two paragraphs:

"Following the decision to halt the move to the new hospital, the Cabinet Secretary commissioned two independent reviews. The first by NHS National Services Scotland to undertake a detailed assessment of all systems in the new hospital that could impact on safe operation for patients and staff. The second by KPMG …

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 … that NHS Lothian has escalated to Level 4 of our performance framework for this specific project."

So, was it your understanding that the government's intervention had been prompted by issues with the critical care ventilation, but that the reports from NSS had identified other matters to be addressed in the interests of patient safety?

A When I joined, we were still to receive the first comprehensive and full report on three areas being looked at by Health Facilities Scotland. Although work on drainage and ventilation and water was underway, those final actions were still to be identified and it was somewhat later that the report into electricity, medical gases and fire were received. I can't remember today what the time-- what time frame that was in, but not all of the actions required had been identified at that point in time.

Q Okay, but as your role essentially developed, was it essentially the work identified in those reports, once they were finalised, and the issue with the critical care ventilation that you were to ensure was carried out?

A Yes.

Q Then just further down in the third paragraph of the letter, picking it up about halfway through, it reads:

> "The Oversight Board will continue to take overall responsibility for the completion of the works and opening of the hospital, reporting directly to the Cabinet Secretary. Underneath that Board, a Senior Programme Director will be appointed, reporting directly to Scottish Government and this will be further supported by additional independent technical advice [and so on]."

The reference there to the Senior Programme Director I take to be a reference to you, but what it says there is that the reporting line will be direct to the Scottish Government, but I think in fact your reporting was done to the Oversight Board. Is that correct?

A It was, and to Fiona McQueen in that regard. Whenever I needed to have contact with Scottish Government, it was Fiona McQueen that I would speak to in that regard.

Q Okay, so as well as your formal reporting line to the Oversight Board, and the Inquiry has got your reports about that, you also had

access to Fiona McQueen as and when you needed to?

A Yes.

Q Okay. NHS Lothian still had in place its project team, or at least members of its project team.

A That's correct.

Q Did you work with them? Did you become an embedded member of that team? Was that how it worked?

A That's correct, yes. I worked very closely with Brian Currie and the team, and indeed with other members of the team. My closest liaison with NHS Lothian was through Susan Goldsmith, although obviously with others, and Brian Currie.

Q One can imagine that, in some circumstances, arriving as a new member of a team that has been in place for a long time might be a challenging thing to do. How did you find the transition into the team?

A It was-- Everybody was very professional and very, very welcoming. There was some uncertainty about what I was there to do, what I was going to do, whether I was going to bring about sweeping changes. I had a really good induction to the team with Brian Currie, I met him there on site on a Tuesday and very quickly, I think we got to know

each other, and I worked as part of that team and as part of, I believe, NHS Lothian's executive team. Not a close part of it, but I attended the executive board meetings and had close contact with them.

Q How did the arrangements work between you and Mr Currie? Was it a hierarchy arrangement, or did you work in sort of partnership, or how did that function?

A We worked together collaboratively to solve the solutions that were there. I would ask questions, he would ask questions, he would present solutions, then we would go and explore it further, so we worked very collaboratively and very closely together. There was a question about whether Brian would report to me or would continue with his existing lines, but I inserted myself as part of that team. That's how I felt it was anyway.

Q Just in general terms, over the time that you were there, how did you feel that the relationship side of things worked?

A With whom? Between myself and colleagues or----

Q With the NHS Lothian project team.

A It was very positive. Everybody was very keen to make

sure that we made progress, that the work was done. There were some very, very difficult and challenging negotiations to be undertaken with IHSL. I would say even colleagues in IHSL were keen to progress those, despite those challenging pieces. So relationships were professional, sometimes they were commercial, but we all had the same end in mind and that was really important to maintain.

Q Okay. Now, just returning a little bit to your own background, you explain that you had worked previously in the procurement of a health sector building under the NPD structure.

A That's correct.

Q Which I think, given the rarity of that structure, probably makes you quite a rare person, but that was the Jack Copland Centre for the blood transfusion service.

A Yes.

Q Was that a building which had specialised ventilation systems?

A Yes.

Q Can you just explain to us what they were, and what was specialised about them?

A Well, I guess an air handling unit is an air handling unit in different sizes. What is special about

the Jack Copland Centre is that it's a pharmaceutical-grade manufacturing service. It manufactures ATMPs and for that, needs very special cascade. So, grade A is pharmaceutical ventilation cleanrooms, in cabinets; grade B in environment; grade C in corridors; into grade D to where we do our blood manufacturing, and that's a very precise cascade that needed to be delivered. So it's highly complex to get that delivered.

Q When you say cascade, do you mean a cascade of pressure arrangements in the building?

A So it needs a cascade of pressure arrangements to make sure that you have the right mix of positive pressures to be able to push any air contaminants-- I mean, these are cleanroom facilities, so any air contaminants need to be pushed out of those environments in which we're manufacturing those very highly specialised products.

Q Okay. Was that an even more sort of technical ventilation setup than the ones you had to deal with on the RHCYP?

A Yes, because the cascades had to operate differently and there were a variety of different rooms, so it was a different set of circumstances, but, yes, it was highly

complex. Some of the team had had some learning previously from another set of cleanroom facilities that had been put in place, and recognised that those cascades and the balancing of those were really quite difficult, making sure the rooms were all sealed properly, and that increasing the pressure in one area was difficult in another area.

One of the big factors in the Jack Copland Centre was the level of resilience in the air handling units. So these are not things that can be switched on and off without having continuity of the pressure cascade to make sure the air is kept completely clean, and that was the precise issue we had a difficulty with, that there wasn't sufficient resilience, initially, in the air handling units that we had put in place, and those needed to be upgraded and replaced prior to practical completion.

Q I was going to come on to that, but perhaps you could just explain that. You say in your statement that there was a challenge, if I can put it that way, about the ventilation systems. You started to explain it there. Could you just outline for us what the problem was and, briefly, why it was that it arose?

A So there was insufficient- - I can't recall-- Well, there was insufficient capacity, size of motor in the air handling units in the event of failure of one or more of those air handling units. The motors weren't big enough to pick up and maintain the cascade pressures that were in place. So the motors and air handling units' size had to be increased in order that if there was a failure, then the resilience measures would kick into place sufficiently.

Q Was that in origin a briefing issue, or a design issue, or a manufacturing issue?

A I can't recall what it was. It was on testing that the motors were found to be insufficiently sized in the event of a failure of one of the motors.

Q So, to what extent did working on that project give you knowledge and experience of things like the SHTM guidance on ventilation?

A I knew where to look. If I wanted to make a personal reference to something, I knew some of the questions to ask. I had some experience of the challenges that getting ventilation pressures correctly could cause.

Q Okay. You have explained in your statement that this project was procured under an NPD

structure.

A Correct.

Q To what extent did that project give you knowledge and experience of the issues that can arise in an NPD contract structure?

A I think definitely the commercial nature of that, understanding the status of the project agreement, understanding how difficult it was to make changes to anything, especially post-practical completion, and the interplay between the constructors and the FM company who was going to have to maintain that, and the SPV.

Q Yes.

A So it was the experience of having been through that and some of those challenges and difficulties that I recalled.

Q So, when you came into the RHCYP project, did you already have either an expectation or an awareness that renegotiating things was going to be a challenging process?

A Yes.

Q Did your experience on that project bear that expectation out?

A Yes. Well, which project? The Jack Copland?

Q No, no, the RHCYP project.

A Yes, it was highly complex, more complex, more complicated, more complex. Many of our negotiations with the Jack Copland Centre happened prior to practical completion. There were some negotiations that needed to happen after the independent tester at the Jack Copland Centre had opined about whether or not we would accept some of the findings that were there. They were mostly about resilience and the particular nature of having 25 per cent flexibility left in the space, but the negotiations, and particularly the impact on payment mechanism and unitary charge whenever we made changes was difficult. I have to say, I think the negotiations around the Royal Hospital for Sick Children & Young People/DCN were very much more complex than I had anticipated.

Q Okay, and one of the points you made just a moment ago was that the extra complexity comes from trying to do that negotiation after practical completion. Can you explain to us what difference the timing makes?

A Prior to practical completion, one hasn't completed-- so one hasn't accepted the building. In this instance, the building had been accepted by NHS Lothian, and

therefore the unitary charge was being paid, and, yeah, I think that makes changes difficult.

Q Okay. So, you obviously came into the RHCYP project with two important areas of experience: first of all, in relation to ventilation systems and the relevant guidance, but also in relation to the NPD project structure. To what extent was that knowledge and experience that NHSL itself lacked prior to you joining the team?

A I don't-- I don't believe they lacked the knowledge. I think I augmented it and was somebody-- I guess Scottish Government wanted somebody to provide support, additional support, to NHS Lothian and I think I added, perhaps, experience that somebody else may not have brought into that support role, so had an understanding of what they were going through. So I don't believe it's that they lacked it. I think I was somebody who brought an additional knowledge, or somebody who had knowledge of what they were going through, rather than somebody who didn't.

Q Yes, okay. Probably related to these issues of the commercial negotiations we were talking about a moment ago, you say in your statement that relations between NHS Lothian and IHSL were challenging, but that you felt that you were able to make a positive difference to that. Could you just explain to us what it was that was challenging about those relations, and what it was that you were able to bring to help it out?

A I think they were very wary of each other. Multiplex in particular, I think wanted off the site. Their work was done, they had a few things that they thought were relatively minor to do, and then they wanted to get off the site very quickly. Bouygues were very concerned that they had expected to have a hospital up and running and it wasn't up and running, and there was outstanding work to be done and NHS Lothian clearly wanted everybody to do what they were there to do.

The biggest thing was assumption of responsibility for the hospital not being open, and it was very difficult. My role wasn't around attributing any blame or examining what had happened and what had gone before, and I think a lot of people were looking at what had gone before and what happened before. I was really keen that we looked forward and provided solutions to get the hospital open. I think that's the key piece that I

did bring, was actually try to lay those things to one side, and actually everybody bring their skills, bring their responsibilities into the room so we can solve the problem. I think that the "who's to blame" piece did get in the way of relationships.

The other thing that I was not aware of and I still am not wholly aware of is what had gone before I joined the team. So I hadn't seen any of that and wasn't aware of any of that, but there was certainly an air of disquiet, I would say, in the relationships.

Q So, were those concerns about who was ultimately going to have to pay for all of this, perhaps, were those sorts of concerns getting in the way of implementing a solution to get the hospital open?

A Not as broad a sense, it was more of an undercurrent. I think there were particular pieces-- Although my job was about the six areas the HFS wrote the reports on, there were outstanding actions from the first supplementary agreement and the closure of the hospital that needed to be progressed, so those action plans were subsumed into those four areas. The speed and the pace at which those were getting resolved I think were a matter-- they were a

matter of some concern. So, having clarity about who was to do what, when they were going to do it, and the delivery against that was critical, I think, just to bringing everybody together.

Q Yes, okay. You say in your statement that when you arrived, the project team was quite depleted due to retirements or redeployments, and you describe the team as not quite demoralised, but "muted".

A Yeah.

Q The general mood was low. Why do you think that was?

A Because of what they had been through. They had spent, many of them, the latter end of their careers-- they had been very experienced people who'd come to get this hospital built, and I think they took that personally as well as professionally, that the hospital had not opened when they'd expected it to. I think they felt that they had let people down, and that means their colleagues, their friends, and the patients who were due to be served in that area. I think that was very hard for those people who were very professional and who dedicated a large portion of their lives to a very critical project.

Q You say that you were

particularly reliant when you first came in on Ronnie Henderson, who was NHS Lothian's Facilities commissioning manager, but that he was overwhelmed with work. In what sense? Was it a problem of volume of work or was it something else?

A He was so critical, he-- Yeah, I don't believe, actually, that he actually has a formal engineering qualification, but he knew so much and brought so much knowledge of guidance and where to find things. So it was really volume of work. I asked for more staff. It took a little bit of time to get those through; our recruitment process in the health system can be slow. Defining what the job roles were going to be was important, but when those staff came in, we were then able to divide up who was going to take greater responsibility for water ventilation, medical gases, electricity, and alleviate some of that pressure and reliance on Ronnie. Ronnie would have been a single point of failure if something had gone-- if he had been absent for some reason, for example.

Q The issue of the volume of work that was on his shoulders, why had that arisen? Was that something which had arisen as a consequence of the issues with the ventilation in Critical Care being detected, or was it a wider problem than that?

A I can't answer that. I don't know what was there before I arrived, but I knew there was heavy reliance on Ronnie. I don't know how many people were there supporting him prior to that. I was aware that some people had retired and had been moved on to other projects, but I fairly quickly identified that we needed another Ronnie.

Q Another Ronnie? Okay.

A Or two.

Q Yes. So, in due course, was that workload issue something that you were able to address?

A Yes.

Q One of the things that you mentioned in your statement is that the announcement of this public inquiry had an impact on the work that you were trying to do. Can you just explain to us what impact that had?

A So, I can't be scientific in it, I guess it's more anecdotal. I think, first of all, it made members of the wider team – IHSL, certainly Multiplex, Bouygues – anxious about, what was that going to mean from a scrutiny point of view? Were they going to give evidence? They saw me as representing Scottish Government, so perhaps I knew what the terms of reference were going to be, how that

went about. I was able to reassure them or give them-- I had been involved in a previous inquiry, so give them some idea from experience in the past, but also I do believe that it had an impact on what-- This and the wider scrutiny, public scrutiny, media scrutiny, had an impact on whether or not, and who came forward to help us resolve the works.

Q Okay. So, when it was necessary to find, what, designers and contractors----

A Yeah.

Q -- to do the remedial work to the ventilation systems? Your perception was that the fact there was a public inquiry in the background sort of limited the number of options you had in the market?

A Not just the public inquiry, but the wider scrutiny and the wider problems that had been reported. Certainly, a number of people would informally mention it was going to be really difficult to get people to come forward and, indeed, I recall one of the Imtech senior people saying that even people who had worked on the building previously who had been contractors had declined the opportunity because of workload, or whatever the reason was, but a contributing factor was the level of

scrutiny and public inquiry.

Q Okay. If we could turn, then, to the remedial works to the critical care ventilation. You talk about this in your statement, paragraphs 45 to 53. I am just interested in understanding the factors that made it complicated. Were those complications largely commercial, associated with the contracting arrangements rather than technical, or were there technical issues there too?

A So, there is no doubt there were contractual commercial considerations, particularly around warranties and how was this all going to be maintained? What was the impact on the payment mechanism? There's absolutely no doubt about that at all. That was complex. We needed to make sure that whatever solution was put into place could be maintained and could cope, potentially, with future change of use, for example, or any additional requirements that came through.

I can't remember the timing of the report that HFS did in terms of fire, but a decision was made that we would install fire dampers into the ventilation system across the hospital. So, we needed to make sure that the fire dampers didn't adversely impact upon the ventilation system, because that is

a concern. If you're putting dampers in, in some ways you're going to obstruct, and will that be adverse?

Also, technically, we weren't clear-- I wasn't clear until Imtech appointed (inaudible) what the final solution was actually going to be for critical care. There were a number of potentials, a number of possibilities, but what would be the best thing to do to rectify that. The other thing that was critical was, actually, what could we do? Because there needed to be site surveys and intrusive surveys undertaken to see what space would actually allow us to deliver what solution.

Q Okay. Is it fair to put it in this way? In both technical terms and in commercial terms, this was a challenging exercise because you were doing it at the end, in other words, after the building had been built, and after all the contracts had been put in place.

A That's correct.

Q Now, as well as the issues with the ventilation, there were other works, and you have alluded to some of those, and those works were based on the assessments of the building that had been recorded in the reports by NSS.

A That's correct.

Q How serious were these issues, in terms of their potential impact on patient safety and care when compared, for example, to the critical care ventilation?

A I guess I viewed them all as being serious and all having to be addressed. Some of those we did have as a project team within NHS Lothian and, at Oversight Board, some discussion about whether they were essential to do. So, for example, fire dampers were considered an additional improvement, and perhaps outwith extant guidance, but perhaps something that was future-proofing, and we had an opportunity to do it, so why wouldn't we do it? Taking a precautionary principle approach.

Certainly, much of the water recommendations were well underway. There were some pieces in there that we had debates about, but we had experts together for the Royal Hospital for Sick Children and DCN that formed a view and we gained consensus around that. So they were all viewed as needing to be addressed, answered, and evidence provided that either refuted the finding, because some of the surveys were not intrusive, so we had to produce the evidence that had previously been there, or we had to undertake works in

order to produce the evidence that they were addressed.

Q Of the various works, you mentioned the fire dampers as being an improvement rather than essential to meet the guidance. Which other elements of the works were in the category of improvements?

A So, I think there were opportunities taken to do some works. So the Lochranza ventilation upgrade, there was-- I don't know where that actually originated from, what the origins of it were, but the opportunity was taken to address ventilation in there.

Q That is the haemato-oncology department?

A Yes. We took the opportunity when CAMHS was being looked at, when we put the fire dampers in CAMHS, and addressing some of the-- I think there were some electrical issues in CAMHS, to do other pieces for the CAMHS staff that there maybe had been incidents, or there had been recommendations that had come through that we took on board and were addressed in that space. There were some learnings from COVID and through COVID, so we took the opportunity to make some changes to the emergency department at that time that would be considered

improvements.

Q Okay, and if we look at it through the other end of the prism, the critical care ventilation works were regarded as essential to comply with the guidance.

A Yes.

Q Which other pieces of work fell into that category, the essential category?

A I would need to go through the list of all of the actions we went through in order to be able to be accurate around that.

Q I mean, the critical care ventilation works, that was obviously a big job. Were there other major pieces of work so far as you can recall that were in the category of essential?

A I would have put Lochranza into that space even though know the guidance-- You know, did it meet the guidance or did it not? I think it was critical. They had resilience issues in there around their single rooms operating from one air handling unit that meant, in order to maintain that air handling unit, you'd have to take out all of those rooms, and the likelihood of having those rooms not having patients in them who required that level of care, I suspect, would have been low. So, I think that was an important one to do. It's difficult to

say. I would have said that was an essential from my perspective.

There was discussion about fire dampers. Why would you not take the opportunity to do that and to make the hospital as safe as it possibly could be? So, yeah, I think everything that we did, really, came into that. Although there were improvements made, I think they would have been essential in the future. I think it's a timing issue.

Q Okay. Now, your role was not to deal with the migration of services in itself, but rather it was to determine when the new facility or parts of it were ready for services to be phased in. Is that right?

A Yes.

Q And you described the phasing of the moves in your statement. So the DCN move had occurred by July 2000, CAMHS in January 2021, and then the rest of the hospital was fully opened in March 2021. In terms of your remit, by the time that each of these parts of the hospital opened, had you been satisfied that it was a safe environment for patients and complied with applicable standards and guidance?

A Yes.

Q And you were obviously there to exercise judgement about

that, but you refer in your statement to the expertise that sat on the Oversight Board and to the additional assurance and expertise that they brought, and you say that that was of considerable value. Could you just expand on that, please?

A So, not just the Oversight Board, because one of the things that we did make sure that we had, and had improved upon, was authorising engineers throughout the duration of the project. The project had already had authorising engineers, but I believe they were much more heavily engaged throughout the remedial works than they had been previously. So they were more a part of the ongoing advice rather than stepping in to do checks at various times, but the Oversight Board had membership of-- from Health Facilities Scotland, who provide-- Scotland's experts in that area to provide advice and support. Jackie Riley, who has international expertise in healthcare-associated infection, and also they have the teams of what's now Assure, but was ARHAI and HFS, behind them to bring that level of expertise and a certain level of independence also to that space. So they provided scrutiny of the scrutiny and the validations that had been undertaken, so we covered it

off from all areas.

Q So, as well as providing scrutiny, were they able to make suggestions about things and so-- or to provide technical assistance if that was needed?

A So, absolutely, but it wasn't just the Oversight Board. So I would have fairly frequent conversations with, for example, Eddie McLaughlan, who was a member of the HFS team, or with the consultant nurses from ARHAI about any particular issue or particular problem to seek advice about, either, "Actually, we've got a dilemma. What do we do about it?", or, "We have a dilemma, we've got a problem. Where can we get the particular advice that is needed to help us come up with a solution?"

Q Okay, and you refer in your statement that you did not always agree with these people. Can you just expand on that a little bit? What kind of things were you disagreeing about and how were those disagreements resolved?

A So the disagreements were resolved by having everybody in the same room at the same time, either face to face or virtually afterwards, so that we could all hear each other's perspectives and have the conversation. I think I've made

reference to one of the examples in there which is about, "Do we need to strip down all of the taps?", for example, and that was brokered by having both Lindsay Guthrie, Donald Inverarity, and the HFS and HPS teams in the rooms coming together facilitated by Tracey Gillies, so we could reach agreement on the way forward with that.

There were some other things where we really wanted-- where I would ask for advice and was directed back to NHS Lothian to undertake a risk assessment, and I think actually the reason for that I have a better understanding about now, and I think it's because there isn't one answer that fits everybody. It really is important that risk assessment is taken-- takes account of the patient group and also the nature and type of care that's going to go on in that particular environment.

Q And just that last point that you made, is that always necessarily going to be a feature of dealing with the risk of infections in the built environment, that it is always going to have to be a project-specific decision-making approach? Or is there scope for imposing standards, if I can put it that way?

A So, it would be good if

there was more certainty around the guidance and if learning could stand still for a period of time. In any project, and particularly one with the length of time, the longevity-- even at the Jack Copland Centre, at the time that we were specifying our requirements, for example at the Jack Copland Centre, even in that period of time there was new learning and perhaps changes or expected changes to guidance, and that always happens. So it would be really good if we could get something that actually could stand still for a period of time and we didn't layer on new guidance, but the rate of change in healthcare, the rate of change in technology, the rate of learning around the built environment, is taking place at a pace.

Q Yes, okay. In terms of how things might be done better in the future, one of the things you suggest is that Infection Prevention and Control staff should be assigned full time to projects of this magnitude. Could you just expand on what you had in mind in that regard?

A So, actually, it's not just Infection Prevention, I guess, and Control staff. I think it's more broadly than that. A project of this magnitude should have its own team who perhaps know-- they need to know of the

patient care, the nature of the healthcare that is going to be provided in the environment, but they should be dedicated to that project on a full time basis. What I was meaning is that very often when you have a project, you'll have people who have a day job which is whatever they were doing before the project came along and they will be consultants to the project rather than an integral part of the team, and they should be more consulting with from the project, rather than doing their day job and being consultants of the team, and I think that's true for FHIR, for example, that we should take knowledgeable people into that space.

Q Are you talking to some extent about clinicians in that role, or is it medically qualified people that you are talking about or technical people who-- FHIR and ventilation and so on?

A All of the above. So, it's absolutely critical that authorising engineers are identified and are part of that and part of the team. So that they're not just coming in and inspecting when work has been done and completed, that they're part of that the whole way through and, likewise, I think infection control doctors and nurses, a doctor, a nurse should be an integral part of that team. The reality

is I think it needs a whole multidisciplinary team to be able to deliver a project.

Q The Inquiry has heard evidence from infection prevention and control professionals, and one concern that they have is that they are too readily seen as the default answer to every issue when it comes to the infection risk of the healthcare built environment and, in fact, are starting to face demands which go beyond their professional competence. How does one get around that difficulty?

A I think I've also said in my statement that infection prevention and control doctors and nurses are in short supply. I think the demand for them has grown over the years. There is no doubt about that at all, so we do need to have more of them. Obviously, the pace of new builds/refurbishments will probably decline over the next couple of years, but perhaps that gives us a window of opportunity to really decide what is needed and what we do want and how best we make sure that these issues are addressed more fully.

What I think is really important and what I think came across from many-- well, from examples in this project is, on the one hand, you have clinicians, nurses, doctors who want to

deliver healthcare. They're concerned about their particular specialty, they're concerned about flow through department, they're concerned about how they might cohort patients. That's what's-- How to bath patients, bathe them. That's what their concern is, and you have then a project that's doing the built environment. They all need to come together in one space to get a shared solution to those issues and problems because that is what I think causes some difficulty.

If you address the built environment issues, are you compromising something that might be needed for healthcare delivery? If you deliver the healthcare delivery, is that something that compromises or needs and requires a compromise in the built environment? And somehow they have to come together in one effort, better than they have done before.

Q Okay, and the model for healthcare construction projects in Scotland is that it is the health boards themselves that are responsible for those projects and for their successful outcome. Is that a model which you think is appropriate or are there other ways of going about it that might be better?

A So, of course, I am now the chief executive of NHS National

Services Scotland and NHS Assure is one of my departments. So I believe the accountability and the responsibility should lie with the Health Board, and the reason for that is NHS Assure is really about the built environment and Infection Prevention Control. It has those two aspects that come together for the built environment.

What they don't have, necessarily-- they will have awareness of it, but they don't necessarily know, what is the nature of the patient, what is the nature of the healthcare specifically within that hospital. So the reason why you build a hospital or a healthcare environment is to provide services. When people come to a hospital, they maybe see the building looks nice and it looks clean, but they're really concerned about the care they're going to receive, the treatments that they're going to receive, how fast it is. So it's about the services that are delivered, and I don't see that Assure could have the accountability and responsibility for those services.

What's really important is that there is clarity of role and responsibility, and perhaps-- I think that's something that always emerges and changes and as there's questions, we work that through. So perhaps we

do need to think about that again, but what is really important, that we collaborate and we work together. We are one NHS in Scotland and that's important to remember.

Q That last point is perhaps the answer to this question but is there a risk-- The aspiration with Assure is to build up a centre of excellence----

A Correct.

Q -- and group all the expertise together. Is there a risk that in a world of limited resources and limited people that all the best people end up in Assure, and then the health boards who have the responsibility of delivering the projects don't have the people that they need in their team?

A So, staff with expertise will move according to a whole range of reasons and different experiences that they might want to have. Job families in Scotland, not just in engineering and Infection Prevention Control, experience a range of market pressures. So digital is quite difficult to recruit to just now, and depending on geographical reasons, there may be more remote, rural areas who have difficulties in securing some particular people. So I don't necessarily believe that that is only true, for example, of Assure. I get that it's in this set of circumstances.

We have seen some movement from boards into Assure, but we've also seen quite a lot of movement from Assure into NHS boards. I understand Julie Critchley will be giving evidence in later weeks, so she would be able to answer in more detail about what those numbers look like, but I think we'll find that there is fluidity across those spaces. It would be really great if we could have one workforce that had the ability to move and that were fluid. We try to achieve that and try to work together in support of the boards.

Q Yes. Thank you very much, Ms Morgan. I have run well past our scheduled end time, but thank you for answering my questions. It may be that Lord Brodie or some others have questions for you, but----

THE CHAIR: I have no questions, Ms Morgan, but I would like to give the rest of the people in the room an opportunity to confirm with Mr McClelland whether or not there are further questions they would like to be directed to you. I would hope that we will only detain you another 10 minutes or so----

THE WITNESS: Okay.

THE CHAIR: -- but can I ask you to return to the witness room?

(Short break)

THE CHAIR: Mr McClelland?

MR MCCLELLAND: Thank you, my Lord. There are no further questions for Ms Morgan.

THE CHAIR: I understand there is no further questions, Ms Morgan, which means you are free to go but, before you go, can I say thank you? Thank you for your attendance, but also thank you for the work in preparing the statement because it is both your oral evidence and your written statement that is available to the Inquiry and both these sources of evidence are very helpful. However, you are now free to go.

THE WITNESS: Thank you, Lord Brodie. Thank you.

MR MCCLELLAND: Thank you.

THE CHAIR: And I should say a thank you for the attendance of everyone in the room, a longer day than perhaps usual, but thank you for being here. Ten o'clock tomorrow, Mr McClelland?

MR MCCLELLAND: Yes, with Mr MacGregor, I think, tomorrow.

THE CHAIR: With Mr MacGregor?

MR MCCLELLAND: Yes.

THE CHAIR: Right. Well, we shall see each other tomorrow at ten.

(Session ends)

17:15