**Scottish Hospitals Inquiry**
**Witness Statement of**
**Michael ("Mike") Baxter**

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## Introduction

1. My name is Michael (Mike) Baxter. My details are known to the Inquiry. I have already provided the Inquiry with witness statements dated 20 April 2022, 14 February 2023 and 4 April 2023 and gave a full day of oral evidence at a hearing on 16 May 2022. I am providing this further statement in order to assist the Inquiry with its understanding of the Scottish Government's role in relation to the procurement and construction of the QEUH/RHC (referred to throughout my statement as "the Glasgow Project").

2. In this statement I shall cover:
    a. Role within the Scottish Government
    b. Outline Business Case and Funding
    c. Procurement
    d. The Capital Investment Group ("CIG")
    e. Design and compliance with SHTMs
    f. Feedback or follow-up issues with the OBC and FBC for the QEUH/RHC
    g. Role on NHSGGC's committees
    h. Building Research Establishment Environmental Assessment Method (BREEAM)
    i. Miscellaneous

## Role within the Scottish Government

3. As I have outlined in my previous statements, I have been a qualified accountant since 1992, having qualified through the Chartered Institute of Public Finance and Accountancy (CIPFA). I also hold a BA (Hons) degree in business studies.

4. The detail as to my historical employment by the Scottish Government in a number of finance related roles is already a matter of public record, so I do not repeat it here in detail. In summary, between August 2002 and 15 February 2009, I was employed as the Head of the Private Finance and Capital Unit within the Scottish Government Health and Social Care Directorate ("SGHSCD"). As I explained in my witness statement dated 20 April 2022, in this role I was responsible for the capital budget for the NHS and private finance policy. I reported to David Hastie, who was then Deputy Director (Capital Planning and Asset Management) within the SGHSCD. As part of this role, I was also a member of the Capital Investment Group ("CIG"), the remit and workings of which, again, I have already provided detailed explanation in my witness statement dated 20 April 2022 and in the full day of oral evidence I gave to the Inquiry on 22 May 2022. For convenience, I would reiterate that my key responsibilities included:
   - Preparing, allocating and monitoring the capital budget for the Health Directorates and NHSScotland.
   - Leading on the development of Spending Review capital investment strategy input for health.
   - Reviewing and approving capital investment plans within Local Delivery Plans.
   - Development of appropriate procurement methodologies to support capital investment.
   - Providing direct advice to Ministers and Senior Officers on capital and Public Private Partnerships ("PPP") related matters as they affect Health.
   - Providing advice and support to NHSScotland in their development of infrastructure investment proposals and procurement in accordance with the Scottish Capital Investment Manual ("SCIM") https://www.pcpd.scot.nhs.uk/Capital/scimpilot.htm **(Bundle 3, Volume 2, Document 33, Page120).**
   - Developing and updating appropriate guidance in support of infrastructure investment.
   - Reviewing Business Cases for Infrastructure investment and providing advice to the CIG on capital related matters.

5. I was subsequently appointed to the role of Deputy Director (Capital Planning and Asset Management) within the SGHSCD and held this position between 16 February 2009 until the end of December 2014. The Capital Planning and Asset Management team were responsible for Health, Infrastructure, Investment, and Public Private Partnerships, as they applied to the National Health Service for Scotland ("NHSS"). As Deputy Director, I was responsible for the Scottish Government's infrastructure investment policy for the area of health and social care. Further detail on the specific responsibilities of that role is detailed in my previous statement dated 20 April 2022. Of most relevance is that, as Deputy Director, I was Chair of the CIG. The Director at that time was John Matheson, who was Director of Finance and Information within SGHSCD.

6. My involvement in relation to matters relevant to this Inquiry ended in December 2014.

7. At the point in time when I joined the SGHSCD in 2002, discussions were ongoing around the Acute Services Review ("ASR") that had been undertaken by the then Health Board, NHS Greater Glasgow ("NHSGG") between 1998 and 2001. The ASR had identified that there were significant challenges to the sustainability of the then configuration of healthcare services across Glasgow **(Bundle 48, Document 5, Page 297).** It recognised the need to improve, create more efficient and effective patient pathways and modernise aspects of the healthcare estate. The ASR was, essentially, the rationalisation of the hospital estate and configuration of healthcare services in Glasgow. The ASR culminated in NHSGGC's Acute Services Strategy ("ASS"), which was approved by the Scottish Government's then Minister for Health and Community Care, Malcolm Chisolm, in 2002.

8. I was not directly involved in any of the discussions about the ASR in 2002, but I understand that the discussions were focused on the high-level configuration and delivery of healthcare services in Glasgow rather than the finer details of matters, such as any new building design or procurement in relation to that.

9. As I also explained in my witness statement of 20 April 2022, my former colleague, Norman Kinnear, was heavily involved at the earlier stages of the QEUH project. He was the Scottish Government's PPP Facilitator and Major Capital Projects Advisor. He left Scottish Government in around December 2011 and sadly passed away a number of years ago. Norman used to attend Project Board meetings for all major investment projects, including the QEUH. When Norman became ill, I started attending those in an observer capacity, however, cannot recollect specific dates. Scottish Government representatives attended project board meetings in an observer capacity given their roles in the approval of projects as members of the CIG.

**The Capital Investment Group**

10. As I explained in my earlier statements, and as has been noted within the Inquiry's Interim Report in relation to the RHCYP/DCN at Chapter 10, the Scottish Ministers' oversight of healthcare infrastructure projects was conducted via the business case review process undertaken by the CIG. That process is an iterative one and involves regular dialogue between those within the Scottish Government Health Directorates ("SGHD") the health board, Scottish Futures Trust ("SFT") (for revenue funded projects), Health Facilities Scotland ("HFS"), Health Protection Scotland ("HPS") and others. As I explained in my statement dated 20 April 2022, the CIG received advice and support on planning, procurement, construction and facilities management issues from NHS National Services for Scotland ("NHS NSS") and the SFT. The CIG also obtained advice from relevant clinical and policy colleagues, as appropriate depending on the nature of the services to be provided from the facilities in question. As I explained in my oral testimony, I was also supported by some of my staff within my division, particularly on Finance and by Norman Kinnear. Norman was originally brought in from the NHS and had experience of delivering healthcare infrastructure projects. We had clinical input; we had analytical input in terms of the option appraisals that were done as part of the business cases; we had representation from Finance because the implications of these projects weren't simply about capital but about revenue and cost; and

we had representation from performance management who had an overview of the performance of NHS boards and their operation. We also had representation from the Chief Medical Officer's Office and Chief Nursing Officer, depending on the nature of the issues being discussed at any given time. As such, there was a very wide-ranging degree of input, providing a holistic view on business cases rather than simply concentrating on the finance. There was no engineering or architectural expertise on the CIG, however the CIG, through me or my Team, would have sought advice from Health Facilities Scotland on any queries raised by an NHS Board or from the content of a business case where an issue required clarification or advice.

11. The ultimate role of the CIG is to provide advice to the Director General that the conditions of the Scottish Capital Investment Manual ("SCIM") have been complied with **(Bundle 48, Document 3, Page 136).**

12. Standing the passage of time, I am reliant upon documentary evidence to refresh my memory as to what was discussed, with whom and when. I am, therefore, not, at this distance, able to recall detail beyond what is stated in the Minutes to relevant meetings of the CIG. I have not repeated the wording of Minutes of the CIG within this statement, as they speak for themselves.

**Outline Business Case and Funding**

13. My first direct involvement in the Glasgow Project began in around 2007 with the provision, through the CIG, of review and support of NHS Greater Glasgow and Clyde ("NHSGGC") in the development of their Outline Business Case ("OBC").

14. As I have explained in my earlier statements and oral testimony, health is devolved in Scotland and SGHSCD is responsible for the delivery of health and social care, through NHS Scotland's delivery arm, which is formed of 22 Scottish Health Boards. The Scottish Government's Health Finance Directorate (now the Health and Social Care Finance Directorate) is responsible for administering the capital healthcare budget for all 22 Health Boards in Scotland,

which includes financial approval of large healthcare projects over the Health Board's delegated financial limit. At that time, the delegated limit was £5m (see Hearing commencing 9 May 2022 – Bundle 4 – Single Bed Derogation, Document 11, Page 146) I can't recall the earlier version extant in 2007 but can recall that £5m was the limit for all boards; there was no differentiation based on size of NHS Board). The ultimate responsibility for the delivery of these projects lies with the relevant NHS Health Board.

15. I have explained the operation of the CIG at paragraphs 10 to 50 of my statement dated 20 April 2022 and expanded upon this in my oral testimony given on 16 May 2022. As I have explained, business cases for projects above Health Board delegated financial limits are reviewed by CIG at different stages of a project's lifetime to ensure, amongst other things, that health needs are appropriately met by the development proposed by the Health Board and that the development is affordable. This process is conducted in accordance with the SCIM.

16. The OBC was finalised by NHSGGC in February 2008. It represented phase 2 of the ASR. The purpose of the OBC was to set out the preferred proposed option for the new integrated Children and Adult Hospital and a new laboratory built on the site of the then Southern General Hospital. As with the discussions around the ASR, the OBC did not go into extensive detail about the proposed design of the building, or exact procurement model that would be used. Instead, the OBC set out a shortlist of service options alongside the cost, risk and benefit of each, in order to assist in the identification and validation of the preferred service option and how that would be delivered.

17. There would have been discussions between NHSGGC and the Scottish Government prior to and during the submission of the OBC as part of regular engagement on the capital programme and development of the OBC. I have no recollection of specifics except in relation to the consideration of the financing route, in relation to which I had a number of discussions with Douglas Griffin, the then Director of Finance for NHSGGC. This was in connection with the modelling of a PPP against a public capital option and the impacts on

NHSGGC's financial plans and affordability. I cannot recollect any dates or exchanges specifically.

18. NHSGGC's OBC for the Glasgow Project was appraised by the CIG on 14 March 2008. Prior to the OBC reaching the CIG, it had been assessed and approved by NHSGGC through its internal governance processes. Additionally, the OBC was subject to a Gateway Review, which was an independent review commissioned by the Scottish Government. I can't recall the detail save to say that the Gateway Review process was overseen by the Scottish Government Programme and Project Team and that, under Gateway Review, the reports are prepared for the Project Senior Responsible Officer (Robert Calderwood NHSGGC's Chief Executive) and shared with the DG Health and Social Care.

19. The CIG plays a vital role in providing assurance to the Scottish Ministers and the SGHSC Management Board, that proposals from Health Boards are robust, affordable and deliverable. The CIG is the vehicle through which that assessment is made prior to it being considered by the Scottish Cabinet (if necessary). The CIG recommended that the Scottish Cabinet should approve NHSGGC's OBC.

20. Following consideration by the CIG, the OBC was submitted to Cabinet of the Scottish Government with a recommendation for approval in April 2008. There was an oddity about this OBC because it should have been presented to Cabinet by the then Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon, but instead went to the then Minister for Public Health, Shona Robinson, due to the proposed Glasgow Project being built in Nicola Sturgeon's constituency, Glasgow Govan.

21. I prepared, with input from SGHD colleagues, a briefing paper for Cabinet, which provided a summary and explanation of the content of NHSGGC's OBC **(Bundle 48, Document 7, Page 308).** At this time, there was quite a lot of discussion around the proposed procurement and funding model for the Glasgow Project due to a number of challenges and changes to the financial

environment. These challenges, as detailed in my earlier evidence to this Inquiry, were related to the 2007-2008 financial crisis and the ensuing 36.5% real term reduction in capital funding available to the Scottish Government arising from the UK Government's Comprehensive Spending Review ("UKCSR"). Additionally, as explained to the Inquiry before, there was also a change to the balance sheet classification of Non-Profit Distributing ("NPD") model funding as a result of the guidance on Managing Government Deficit and Debt ("MGDD") associated with the application of the European System of Accounts 95 ("ESA95"). The changes to these accounting rules meant that, if the Glasgow Project were to proceed with public funding, then it would need to be through public capital funding.

22. The then challenges and changes to the financial environment were key considerations in the decision that the Glasgow Project would need to proceed with public capital funding. As the Inquiry has already heard, independent advice was obtained by NHSGGC from EY (previously known as Ernst & Young), which assessed various models for proceeding. NHSGGC selected and took forward the option recommended by EY[1].

23. The briefing prepared for Cabinet took account of a value for money and affordability analysis comparing the public capital funding option against a non-profit distributing model option. Overall, the public capital funding option was calculated as providing best value to the public purse, per the Scottish Public Finance Manual, because the additional revenue cost of the public capital funding option stood at £53.4m per year as compared to £76m per year for the non-profit distributing option. On that basis, the briefing paper to Cabinet recommended that it approve the CIGs recommendation of NHSGGC's OBC, with the consequence of an additional net capital funding of £108m over six years being provided by the Scottish Government; and for NHSGGC to proceed to procurement.

[1] Inquiry document reference for EY report not found, however, EY report referred to and summarised in Bundle 17 page 1811-1813

24. On 8 April 2008, the Scottish Cabinet accepted the CIGs recommendation and approved NHSGGC's OBC. The only stipulation that the Scottish Government had in relation to the OBC was that any movement in anticipated costs of more than 10% would require the Health Board to prepare an updated OBC. The Scottish Government provided the Glasgow Project with priority for capital funding despite the change in the allocation of funding to the Scottish Government as a consequence of the UKCSR. The cost of the Glasgow Project was more than a third of the total capital budget for the NHS in Scotland over several years, so was a significant investment. The Scottish Government was nonetheless satisfied that the Glasgow Project was affordable based on the assumptions set out in the OBC.

25. The Scottish Government's approval of the OBC permitted NHSGGC to proceed to procurement and develop a full business case ("FBC").

**Procurement**

26. Following the OBC being approved by Cabinet in April 2008, NHSGGC proceeded to procurement and continued its development work of the preferred service option for the Glasgow Project.

27. The Glasgow Project proceeded as a design and build project under the National Engineering Contract Three ("NEC 3"). This was entered into between NHSGGC and Brookfield Construction (UK) Limited ("Brookfield") on 18 December 2009.

28. I understand that NEC 3 was the contractual model of choice for the Glasgow Project because of its mechanism for sharing risk between the contracting authority and the contractor. I had limited direct involvement in the procurement or contractual arrangements in relation to the Glasgow Project. Norman Kinnear would have been the lead Scottish Government interface on the project at the time that those discussions/ decisions would have taken place. NHSGGC were the contracting authority for the Glasgow Project and retained responsibility throughout. Decisions for NHSGGC were made through their

Performance Review Group ("PRG") through delegated authority from the Board (see **Bundle 34** for PRG papers). HFS might provide the Inquiry with any further technical input it requires in relation to NEC 3 as the body responsible for overseeing Framework Scotland, which was the national framework for agreements surrounding public capital projects within the NHS in Scotland.

29. NHSGGC provided the Scottish Government with periodic updates on their progress of work, the selection of bidders and the progression of the contract. As part of my then role as Deputy Director, I would hold fairly regular meetings with Douglas Griffin, the then Director of Finance at NHSGGC, to review NHSGGC's financial and capital position. These meetings with Mr Griffin formed part of the wider duties of my role as Deputy Director in terms of oversight of the financial position of NHS Health Boards in Scotland in relation to their capital budgets, as opposed to any responsibility specifically related to my role as Chair of the CIG.

30. I was part of the New South Glasgow Hospitals and Laboratory Project Executive Board ("NSGHLPEB") for the Glasgow Project in an observer capacity only. The NSGHLPEB was set up by the NHSGGC Performance Review Group (an internal NHSGGC group that I was not party to) on 19 May 2009 **(Bundle 34, Document 21, page 145 at page 153)**. That decision is recorded at Item 32 of the Minutes of 19 May 2009 **(Bundle 34, Document 20, page 134)** and the Paper (Report of NHSGG's Director of Acute Services Strategy, Implementation and Planning – Paper No. 09/21) referred to therein at Item para 2.3-2.5 **(Bundle 34, Document 20, Page 147).** That Paper included Terms of Reference for the NSGHLPEB together with the proposed membership **(Bundle 34, Document 20, Page 147 at Appendix 2, Page 152).** I was listed in this document as a voting member of that group. I do not recall seeing the Terms of Reference for the NSGHLPEB or having been consulted on the text of this. I was not present at the meeting of the NSGHLPEB on 1 June 2009, which was attended by Norman Kinnear and I cannot recall seeing papers in advance of that meeting. Given my role as Chair of CIG and consequent involvement in a number of projects at the time, it was not

appropriate that I should be a voting member of the NSGHLPEB. This was addressed on 7 December 2009, when I attended the NSGHLPEB, having raised the issue in advance as a result of having had sight of the draft papers (**Bundle 42, Volume 2, Document 17, Page 85 at Pages 86-91**). As such, my attendance at the NSGHLPEB was always as an observer. My role was to track the development of the project in terms of cost to the Scottish Government and published timescales to ensure that it remained within the tolerance that had been set by the Scottish Government in terms of the overall capital budget for the NHS in Scotland. I did not have any professional expertise beyond that limited finance remit or any decision-making role on the Project Board.

Site Selection

31. The plan for the Glasgow Project was for the triple co-location of adult, children and maternity services. My direct knowledge of the discussions that NHSGGC had in relation to the site selection are limited to the information that would have been contained in the OBC and, latterly, the full business case ("FBC"). From memory, the Scottish Government's involvement in any discussions around site selection would likely have been handled by their Performance Manager who, at the time, was Carmel Sheriff or other colleagues within the Scottish Government's Performance Management Division as well as by David Hastie the then Deputy Director (Property and Capital Planning).

32. From the high-level knowledge that I do have, I recall there being a natural gravitation from NHSGGC towards the Southern General site because a maternity hospital had recently been built there and another hospital in the vicinity within Govan was due to be replaced through the ASR. The reconfiguration of services in Glasgow, especially with the reduction in standalone hospital sites, also led to discussions about the appropriate split of healthcare services between the north and south of Glasgow. This site offered triple co-location of maternity, children's and adult care. These factors, together with the availability of space on the Southern General site, seemed to be the rationale for building the Glasgow Project there.

33. I recall reading a discussion paper addressing the sewage works in the vicinity of the Southern General site. I do not recall any of the finer details around this and was certainly not involved in any discussions or decision making concerning this.

Design

34. The design team for the Glasgow Project was appointed in March 2009. The design for the Glasgow Project was prepared by Nightingale Associates, with construction carried out by Multiplex, who had previously undertaken major infrastructure construction projects, such as Wembley Stadium.

35. I was part of programme board meetings where NHSGGC provided progress updates on design. My role was that of observer. There was no basis for me to engage in this role upon matters of technical design given my remit. I would refer the Inquiry again to my professional qualifications and particular governmental interest in finance. Other witnesses from NHSGGC/NSS would be better placed than I to provide information on design.

36. I understand that the Inquiry may be interested in the content of certain Chief Executive Letters ("CEL"). I have already provided evidence to the Inquiry as to certain CEL's that I am named within. My name is on CEL 19 (2010) because it relates to capital investment and I was policy lead in relation to that, however those CELS were developed by colleagues in the hospital acquired infection teams in the Chief Nursing Officer's Directorate. I had no direct involvement in the development of that guidance.

37. I understand that the Inquiry is interested in the selection and installation of taps within the QEUH. As an accountant, I cannot speak to that. I understand that the Inquiry has or is seeking evidence on this from those with relevant expertise within Health Facilities Scotland.

38. As far as I was aware at the relevant time, the design processes were followed as intended and the Glasgow Project was delivered on time and within budget.

There were no issues flagged by NHSGGC to the Scottish Government during the business case process. As I have mentioned, I left my post as Deputy Director in December 2014, so the first time that I was aware of issues raised with the built environment of the Glasgow Project was through what was reported publicly within the press.

**Full Business Case**

39. NHSGGC's FBC **(Bundle 37, Document 42, Page 562)** was considered by the CIG on 9 November 2010 **(Bundle 48, Document 10, Page 332).** As with the OBC, this represented the final stages of review following consideration of the FBC through NHSGGC's internal governance structures and external Gateway Reviews. The Scottish Government's approval of the FBC was an essential stage in allowing the Glasgow Project to proceed to construction.

40. The FBC is a detailed document that sets out the agreed commercial arrangements for a project. The FBC was developed within the final procurement stage. The role of the CIG was to examine the extent to which the FBC matched national, regional and local priorities set out in Local Delivery Plans and associated Property and Asset Management Strategies; and to provide assurance to the Scottish Government that all aspects of the business case were appropriate, affordable and achievable.

41. My recollection is that, whilst the FBC would have been formally submitted by NHSGGC to the CIG on 22 October 2010 and comments were expected and provided from the CIG by 3 November 2010, there had been prior engagement with the CIG on the FBC development through presentations given by NHSGGC colleagues, including Helen Byrne (from memory). I cannot recall the specifics of this given the passage of time but it would have been typical for draft documents to have been provided by a health board and reviewed by the CIG's members prior to finalisation of the document. I would also add that a timetable for business cases was submitted to the CIG so that there was awareness of when business cases were due for submission and review, so that appropriate work could be planned by CIG members **(Bundle 48,**

**Document 9, Page 330, Bundle 52, Volume 1, Document 20, Page 278 and Bundle 48, Document 10, Page 332).**

42. I am asked whether NHSGGC disclosed the ventilation derogation recorded in the M&E Clarification Log **(Bundle 16, Document 23, at the foot of Page 1664)** and proposed in the ZBP Ventilation Strategy Paper dated on or around 15 December 2009 **(Bundle 16, Document 21, Page 1657)** within the FBC or to the CIG in any other way; and had they disclosed it would it have been discussed, considered, approved or challenged by the CIG at that time. I can confirm that there was no such disclosure. Had any such disclosure been made, technical advice would have been sought from HFS on the implications of any such derogation and, on the basis of that advice, issues raised with NHSGGC prior to any approval.

43. It is recorded in the meeting minutes of 9 November 2010 **(Bundle 48, Document 10, Page 332)** that I recommended that the project be considered via expedited procedures once the outstanding issues were resolved. I believe that there was a further check required on the financials in the FBC but cannot recall the specifics. Expedited procedures meant that when there were outstanding issues these would be recorded and dealt with via correspondence with the relevant CIG members. This allowed consideration to be closed out without having to wait for the next formal CIG meeting. Any such issues should have been minuted at the following meeting as either being resolved or not.

44. Norman Kinnear prepared a briefing paper for the Minister for Public Health and Sport dated 9 December 2010, within which it was recommended that the FBC be approved **(Bundle 52, Volume 1, Document 21, Page 284).** I cannot recall any issues being raised by the Minister. Had there been any these would have been in written form from the Minister's private office.

45. Similar to the process for the OBC, the FBC was submitted to Cabinet for Scottish Government approval, together with the briefing paper. The purpose of this briefing paper was to, amongst other things, confirm that the proposals set out in the FBC were in line with the phased construction contract signed

between NHSGGC and Brookfield in December 2009. It was recommended that Cabinet approve the FBC. This was subsequently supported by Cabinet **(Bundle 48, Document 12, Page 341).**

**Design and compliance with SHTMs**

46. I understand that the Inquiry is considering derogations from standards within the contract for the Glasgow Project. There were no derogations from standards referred to within the OBC or FBC. I do not recall any derogations being proposed/ sought or forming any part of any discussions at the CIG or taking part in any decision-making about any proposed derogations. Any derogation from technical standards would have required input from HFS and appropriate input from the Chief Medical Officer's Directorate. I do not recall any instances when HFS were consulted on this during the business case process. I cannot comment on the engagement between NHSGGC and HFS on these issues in the development of the project.

47. As I was not sighted on any discussions around derogations from standards, I cannot add anything materially to the Inquiry's understanding of them. What I can say is that any request to the Scottish Government for derogation from air change standards set out within SHTM03-01 would likely have to have been considered and, if appropriate, signed off by the Chief Medical Officer ("CMO"). The CMO would likely have to take advice from HFS, who the Scottish Government would refer to for matters of technical expertise. The standards set within SHTM03-01 are informed by expert clinical and technical input (which is outwith my field of expertise), but my understanding is that the SHTM stipulates the standard that the Scottish Government expects to be delivered for patients in new build hospitals, so if a health board has any intention to derogate from the standard (i.e. not to provide this for its patients) the Scottish Government would expect to be informed of this through the final business case process in order that it can consider whether the derogation sought is acceptable. Mandatory requirement 7 of CEL 2010 19 and the narrative on page 38 of that document covering the Activity Database ("ADB") and that the application of the tool would mean design would be compliant with guidance.

The Scottish Government was not made aware of any derogation from the standard set out for air changes within SHTM03-01 being sought by NHSGGC in relation to the QEUH. No information was presented to me personally or through the NSGHLPEB or CIG. The evidence that I have already given to the Inquiry in relation to my expectations (flowing from the mandatory application of ADB in the design quality policy CEL 2010 19, referred to above) that derogations from standards should be pro-actively brought to the attention of the Scottish Government by the health board as part of the FBC apply equally to the Glasgow Project. NHSGGC did not bring the derogation to the attention of the Scottish Government (either directly to me or by raising it at the NSGHLPEB or CIG) and, as such, the Scottish Government did not have the opportunity to consider it. Agreement from the Scottish Government to any derogation sought would be subject to taking and receiving appropriate technical advice.

48. In my witness statement for the hearing commencing 9 May 2022 **(Hearing Commencing 9 May 2022 - Witness Statement Bundle, Document 5, Page 83)** I discuss at paragraph 111 onwards the issues around compliance with SHTM. I am asked what the consequences would be if an NHS Board failed to comply with a CEL, SHTM or any other legalisation, regulation or guidance in a project that required approval by the CIG. In short, a business case would not have been approved until such matters had been satisfactorily resolved, assuming any such issues had been properly disclosed.

49. I am asked to what extent the Policy on Design Quality for NHS Scotland applied to either of the OBC or the FBC for the QEUH/RHC; did the 2006 Edition apply **(Bundle 3, Volume 1, Document 4, Page 113)**; and what impact did it have on compliance with guidance such as SHTM. The mandatory requirements set out in the 2006 policy would have applied to the OBC and the 2010 requirements to the FBC. The mandatory requirements set out in the 2006 and 2010 policies with regard to use of the Activity Database (and through that design to be compliant with SHTM's) were consistent.

50. I am asked what the relationship was between either of the 2006 or 2010 versions of the Policy on Design Quality for NHS Scotland at the OBC or the FBC for the QEUH/RHC; and whether the Glasgow project underwent the NHS Scotland Design Assessment Process ("NDAP") process either based on the 2006 version **(Bundle 3, Volume 1, Document 4, Page 113)** or 2010 version. As above, the mandatory requirements of the 2006 and 2010 policies were consistent. There is explicit reference in section 6.7 of the OBC to the requirements of the 2006 Design Quality policy and in section 6.9.7 to entering an agreement with Architecture and Design Scotland to deliver on design quality ambitions. I cannot recall whether the NDAP process was applied to the FBC (it would not have applied to the OBC as the OBC predated this requirement).

51. A design derogation from standard policy (such as single room configuration) should have been flagged at OBC stage. Detailed design on ventilation would not have been undertaken at this point, so that was not relevant at OBC stage. It was, however, absolutely relevant that this should have been flagged and tested prior to finalising of the FBC. The ventilation derogation was not recorded in the FBC. In my view, it should have been. My expectation is that an OBC and FBC should record whether a project complies with all legislation and guidance and if not, highlight and bring to the attention of the CIG that it does not. I say this because I would have expected FBC to be compliant with Design Quality Policy.

52. In my view, it would have made a difference to the outcome of the FBC if the derogation had been recorded. An assessment of any derogation sought would have been undertaken and a view taken following receipt of appropriate technical or medical advice. If the request for a derogation had been refused and confirmation was not received from the relevant health board that this refusal had been reflected within a revised business case and the decision complied with, approval could not have been recommended to Ministers.

53. I am asked to what extent I would agree with a group of linked propositions: that the specification of a ventilation system for a hospital will have a direct

bearing on the nature and scale, and therefore the cost, of a large variety of construction features; suitably technical members of the CIG should be able to notice at OBC or FBC stage that a hospital is to have a smaller and cheaper ventilation system than might be expected for a hospital of that size and start asking questions about the long term sustainability and effectiveness of the ventilation system. I would agree only to the extent that any element of the specification will have an impact on cost. I would disagree that CIG members would have had sufficient detail on the specification and costing to form the judgement set out. What I can state is that the expectations on costs were that the building would have been compliant with guidance and at no stage was any suggestion made by myself on behalf of the Scottish Government to take steps to reduce costs of any underlying systems. I would have expected NHSGGC, in conjunction with their Technical and Financial advisers, to have sufficient detail on the costing and requirement for compliant ventilation systems.

54. I am asked what chief executive letters, if any, applied to or referenced the ventilation systems in the QEUH/RHC project; when were they issued; and were any derogations sought. Again, I would reference the Design Quality policy and mandatory requirement 7 regarding use of ADB, which would have demonstrated compliance with standards. No derogations were sought to my knowledge or recollection. The mandatory requirement for use of the Activity Database (ADB) was the same in the 2006 and 2010 policy documents. No derogations were sought.

**Feedback or follow-up issues with the OBC and FBC for the QEUH/RH**

55. There were financial checks required on the FBC, which I believe were minuted. Approval could not be recommended to DG Health and Social Care until all such issues had been satisfactorily addressed.

56. The SCIM gives guidance which applies to the process of project development from inception to post project evaluation. The guidance would have been per the extant SCIM at that time. The OBC and FBC would have been expected to

set out the approach to Post Project Evaluation, but clearly this would not have been conducted at the point of the FBC approval.

57. There is a requirement within the SCIM for NHS Boards to conduct Post Occupancy Evaluations and Post Project Evaluations. The requirement would have applied as per the SCIM. I cannot recall whether these were carried out. A post occupancy evaluation (from memory) would have been conducted 6 months after occupation with a post project evaluation 12-18 months after completion. There were separate manuals within the SCIM covering these requirements. The delivery of large healthcare projects is the responsibility of NHS health boards. In my view, the purpose of the oversight provided by my directorate and the Scottish Government during the design, procurement, construction and post evaluation phases of a major capital project was essentially about timescales and finance. Compliance with SCIM would have been assessed though the OBC and FBC to the extent that all relevant matters, including deviation from standards, was contained within these documents. It is also important to note that the OBC and FBC were the basis of an NHS Board approving the project before submission to the Scottish Government and, therefore, the clear expectation was that a relevant NHS Board should satisfy itself that all requirements had been satisfied prior to submission to the Scottish Government.

**Role on NHSGGC's committees**

58. I am asked about my membership of three groups:
    i. The Procurement and Finance Group - I don't recall being a member of this group; I note from the minute in the pack from 19 Feb 2010 that Stephen Gallagher, the then Deputy Director for Performance Management, was in attendance. Given our respective roles, we would not have substituted for each other;
    ii. New South Glasgow Hospitals and Laboratory Project Executive Board - I do not believe I was a member of this Board, which was internal to NHSGGC;
    iii. Acute Services Strategy Board - I attended as an observer, as recorded in the terms of reference. My role was to receive updates on progress and

financial matters and, in respect of business case development, to provide advice as necessary. I have no recollection of ever receiving information or being requested to provide advice on the same in relation to derogation from SHTM's.

59. I do not recall attending any other NHSGGC groups/ committees/ boards (other than the NSGHLPEB, as discussed above).

60. I was not involved in decisions in respect of site selection for the new SGH, procurement structure and funding and choice of contract model. Norman Kinnear would have attended any relevant meetings to which the Scottish Government was invited in that regard, therefore I cannot comment on the nature of those meetings. I may have been present at meetings when selection of preferred bidder was discussed but cannot recall specifically. If I was in attendance, it would have been as an observer and not part of the decision-making process.

61. I do not recall seeing any reports in respect of removal of the maximum temperature variant in May/June 2009 **(Bundle 17, Document 26, Page 1063 and Bundle 26, Document 3, Page 168)**; approval of changes in the respect of ventilation systems that were not consistent with the terms of SHTM 03-01 (2009) draft; the decision to use chilled beams; the detailed specification of the ventilation systems of what became Ward 2A (RHC), Wards 4B, 4C, 5C and 5D of the QUEH; or design of the ventilation systems of isolation rooms.

62. I have been asked to review items 4 and 5 of the Minutes of the NSGHLPEB of 7 December 2009 **(Bundle 42, Volume 2, Document 18, Page 86)** which I attended as an observer. I am asked whether there was any report that the Brookfield Europe bid remained (at that time) non-compliant with an aspect of the Employer's Requirements in that the proposed ventilation solution would not have been compliant with SHTM 03-01 2009 draft, in that the air change rate for single rooms was proposed to supply air at half the rate than that was called for. Given the passage of time, I am largely reliant on the Minutes to remind me of what was discussed at this meeting, however, I have no

recollection of any reference to the bid having been non-compliant at that time and, should such an issue have been discussed, would have expected that to have been appropriately recorded in the Minute, which it is not.

**Building Research Establishment Environmental Assessment Method (BREEAM)**

63. BREEAM is a tool/ methodology relating to environmental accreditation for buildings. The Design Quality Policy issued under cover of CEL 2010 19 sets out the requirements for BREEAM compliance in mandatory requirement 6. Technical advice in relation to BREEAM would have been available to NHSGGC through HFS.

**Miscellaneous**

64. By reference to a document **(Bundle 42, Volume 2, Document 24, Page 113)** it is put to me that I had advised NHSGGC that any support from HFS would require to be funded by the Board. I am asked the following questions: What was the discussion around this? Did NHSGGC go ahead with specialist equipment support from HFS? The minutes record that you had also enquired whether NHSGGC were considering project cashflow and forward purchase as this had been raised with you by HM Treasury. What were you asked by HM Treasury, how did you communicate this to NHSGGC and what was the outcome? I am inferring the response here, as I was not present at the meeting referred to. Given the scale of the project, HFS was not funded specifically to provide the level of support indicated and, as a result the costs of this support would need to be met from within overall project funding, which included a range of contingencies. I cannot recall what level of support was provided by HFS - representatives of HFS would be best placed to answer. From memory the issue of timing will have related to the drawing down of funding from the Scottish Government to NHSGGC to align with its equipping programme and, in particular, whether large pieces of equipment, such as scanners, needed to be installed during the construction process due to logistics. I cannot see where

the references to HM Treasury and timing are in the documents I have available to me and am unable to recall the detail.

65. By reference to a document **(Bundle 42, Volume 2, Document 25, Page 116)** it is put to me that I confirmed to NHSGGC that all provision of services by HFS (Equipping section) will be chargeable to the project and will not be subject to reimbursement. This is the same issue as above; given the significant capacity required within HFS, this was additional costs that would need to be funded from within the overall project budget, which contained a degree of contingency.

66. I am advised that the Inquiry has heard much evidence "over how it is that in the construction of new buildings it is much cheaper to get things right first time than to have to correct them later" and have been asked if any such consideration formed part of discussions at the NSGHLPEB. From memory I would say that it was only discussed in general terms, (again from memory) through reporting on design development and construction progress once that had commenced.

67. I am asked whether I should have had an element of oversight on the NSGHLPEB "and other NHS GGC committees that [I] attended", given my SG position and, in particular, whether I should have checked that change procedures, which might have had cost implications, were in place and operating. The governance arrangements were established and overseen by NHSGGC and delegation and reporting arrangements flowed from that. The only oversight possible was on the basis of actual information provided to NHSGHLPEB and, subsequently, through business cases or relevant correspondence submitted to the CIG, which had been through NHSGGC governance prior to formal submission to SG. I have already indicated my view that it was NHSGGC's responsibility to raise the derogation with the CIG, but did not do so. On the basis that there was a deviation from standard, I consider that oversight by NHSGGC to disclose derogations represents a significant gap in compliance with mandatory design quality policies and governance expectations. Any proposed derogation should have been advised by NHSGGC to the Scottish Government in order to allow for consideration prior

to approval and implementation, but this was not done. In my view, NHSGGC should also have raised the derogation at the NHSGHLPEB and the governance structure in NHSGGC would have allowed for escalation of significant issues, which in my view would have included any such derogation. I cannot comment on what discussions on this matter may have taken place within other parts of the governance structure to which I was not party.

68. I have been asked whether I have a view as to whether lack of transparency by NHSGGC prevented the necessary evaluation and risk assessment that might have been critical to ensuring patient safety, compliance with standards, and informed decision-making throughout the project lifecycle. I cannot comment on the reasons for the omission of such information but any disclosed proposed deviation from standard would have required evaluation and risk assessment.

69. I have been asked "Is it the case that PFI/PPP ceased to be a realistic option following the change of government from May 2007?" The short answer to this question is "No". The reasons for public procurement were based upon value for money and affordability grounds given changes in accounting standards/ budgeting rules at the time and how these impacted on the Scottish Government and NHSGGC budgets.

70. I confirm that I visited the site of QEUH/RHC to attend Programme Board meetings held in the project accommodation on site and had a couple of tours of the site during construction to see progress. I attended the opening.

71. I am asked for my impression of the QEUH/RHC project's budget pre and post-handover. I have no recollection of any issues on variation to project budget beyond those recorded in the FBC.

72. In relation to whether there is anything further that I want to add that could be of assistance to the Inquiry, I have endeavoured to answer the Inquiry's questions to the best of my ability (recognising the significant passage of time), both in this statement and my previous three statements and day of oral evidence to the Inquiry. There is nothing else I feel I can add at this time.

**Declaration**

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

**Appendix A**

The witness was provided with the following Scottish Hospital Inquiry documents for reference when they completed their questionnaire

A37215538 – Bundle 3, Volume 1 – Governance
A35761409 - Bundle 16 – Ventilation PPP
A32993814 - Bundle 16 – Ventilation PPP
A33010775 - Bundle 17 – Procurement History and Building Contract PPP
A49286669 – Bundle 26 – Provisional Position Papers
A51853180 - Bundle 42, Volume 2 – Previously Omitted Miscellaneous Meeting Minutes and Papers
A35422498 - Bundle 42, Volume 2 – Previously Omitted Miscellaneous Meeting Minutes and Papers
A37217037 - Bundle 42, Volume 2 – Previously Omitted Miscellaneous Meeting Minutes and Papers

**Appendix B**

The witness provided or referred to the following documents when they completed their questionnaire statement.

A51258946 – Bundle 34 – Performance Review Group and Quality and Performance Committee Minutes and Relevant Papers
A51258908 - Bundle 34 – Performance Review Group and Quality and Performance Committee Minutes and Relevant Papers
A34871325 – Bundle 37 – Board Minutes and Relevant Papers
A51853186 - Bundle 42, Volume 2 – Previously Omitted Miscellaneous Meeting Minutes and Papers
A32551720 – Bundle 48 - Provisional Position Paper 15 – Governance and Supporting Documents
A35289380 – Bundle 48 – Provisional Position Paper 15 – Governance and Supporting Documents
A35178847 - Bundle 48 – Provisional Position Paper 15 – Governance and Supporting Documents
A35072360 - Bundle 48 – Provisional Position Paper 15 – Governance and Supporting Documents
A35178847 – Bundle 48 - Provisional Position Paper 15 – Governance and Supporting Documents
A35100870 – Bundle 48 - Provisional Position Paper 15 – Governance and Supporting Documents
A35187175 – Bundle 52, Volume 1 – Miscellaneous Documents
A35072376 - Bundle 52, Volume 1 – Miscellaneous Documents
A37609211 - Hearing Commencing 9 May 2022 - Witness Statement Bundle
A37410080 - Hearing commencing 9 May 2022 – Bundle 4 – Single Bed Derogation