Scottish Hospitals Inquiry
Witness Statement of
Peter Gallagher

1. My name is Peter Gallagher and I retired as Director of Finance of Acute Services with NHS Greater Glasgow and Clyde in January 2015. I am qualified as FCCA (Fellow Chartered and Certified Accountant) and I am now a life member of the Chartered Association of Certified Accountants, and that was in the June ’78 diet, 1978.

2. When I left school, I was working in the South of Scotland Electricity Board as an administration assistant. I moved from there to Collins, the publishers, 1974 to 1976, then from 1976 to 1984 I worked at Neil and Spencer, who manufactured industrial laundry machinery, predominantly for hotels, but also hospitals, interestingly enough.

3. Between 1985 to 1987 I joined Argyll and Clyde Health Board as the chief accountant. I was then promoted to the unit finance officer in 1987 to 1992. So, I was with Argyll and Clyde Health Board from 1985 to 1992.

4. From 1992 to 1999, I was with Lanarkshire Health Board. I was in the Hairmyres and Stonehouse Trust as Director of Finance. I rebalanced the finances there, reestablished the Trust, and I became the Director of Finance and the Project Director for the PFI Hospital, Hairmyres.

5. In April 1999, I joined Glasgow and remained there until I retired but was there in various iterations. From 1999 to 2004, I was the Director of Finance for the South Glasgow University Hospitals NHS Trust, which was the Victoria and the Southern General Hospitals. Previously, they had been individual hospitals. John Connaghan was CEO in Victoria, and Robert Calderwood was CEO in Southern General.

6. In 2004, the numerous individual Glasgow hospital trusts, the North, the South and Yorkhill, were dissolved. I became the Director of Finance for the South Division.

7. In 2005 there was a re-structuring process in NHS Glasgow, quite a stressful one actually and from a finance point of view, NHS Glasgow ended up with two directors of finance. I became Director of Finance (Acute) with responsibility for the acute hospitals and an annual revenue budget of £1.5 billion at my retirement date.

8. NHS Glasgow also created a primary care Finance Director, which was all the GP's, *et al*. The primary care director was also the Board's Director of Finance. So, the Board's Director of Finance also oversaw primary care. I oversaw the acute hospitals.

9. Albeit I left in January 2015, when I came back from the October 2014 school week, I put my notice in, then worked from the October to the January on four days a week/three days a week etc wind down. So, largely, I had a lot less input from October 2014 to January 2015, when I retired.

10. When I joined NHS Glasgow in 1999, Robert Calderwood was the Chief Executive of the South Glasgow University Hospitals Trust, and that's really where NHS Glasgow launched the whole acute services review process. Then when Tom Divers, who was the Chief Executive for NHS Greater Glasgow, restructured in 2006, he introduced a Chief Executive for the non-acute side and a Chief Operating Officer for the acute hospitals.

11. Robert Calderwood became the Chief Operating Officer for the acute hospitals. A Director of Acute Services Planning post was also created.

12. The Director of Acute Planning's job was to oversee the rebuild of Glasgow Hospitals for the bits that had not been done, including bed models and running the project. So, the whole project team sat under here. I was responsible to ensure the capital plan and the revenue plan broke even. I was responsible to the Chief Operating Officer for that.

13. So, the Chief Operating Officer (now referred to herewith as C.O.O.) was then in charge of the £1.5 billion revenue budget, but he had different directorates delivering that. He had a Surgical directorate, a medical directorate, a radiology directorate, which would include labs, a Women and Children's directorate, etc., etc.

14. Each of those directorates had a Director. They also each had a Head of Finance who was responsible to that director. So, the Head of Finance in, say, Women and Children's, was directly responsible to the Director of Women and Children's directorate. I had no line responsibility to that individual, but only a professional link.

15. If there was a financial issue, I would report that back to the C.O.O. It was a financial monitoring role. Then if the C.O.O felt he had to see the Director, he would get the Director in, the Head of Finance in, myself under him, and then he could instruct the Director for whichever directorate to change tack if required. I could not instruct that directorate Head of Finance to change. I was more making sure the division broke even and performance managing the individual directorate's finance.

16. When the Director of Acute Planning left in February 2010, there was a new project structure introduced and that is referenced in your files. The C.O.O then took over the running both of the project and the Acute hospitals. That continued through until I retired in January 2015.

17. Together with being responsible directly to the Chief Operating Officer, I had a strong professional link to the NHS Board Director of Finance.

18. To explain this, had the Chief Operating Officer said, “I want you to do X,” and I thought, “No, I do not think that’s financially correct,” then I could have gone straight to the Board Director of Finance on a professional link, as the Board Director of Finance together with the Board CEO had ultimate say in all Board financial issues.

19. All financial decisions that were taken by the Board would have been approved by the Board Director of Finance.

20. I was not a Board member. I may have on occasion attended the Board meetings because they might want clarity. I suppose it’s a bit like the captain of the ship is the main guy, but he does not run the engine room. You need somebody down there doing the day to day work.

21. The problem with titles is when we were a Trust, we had a Trust Board. I saw this when I went through some of your papers (Bundles). They have an Acute Services Strategy Board, but that is different from the NHSGGC Board.

22. The Acute Services Planning Director was directly responsible to the Board Chief Executive. But the C.O.O and Director of Acute Planning clearly had to work together because one is delivering the project whilst the other is running the hospitals, so they need to talk to each other to manage the whole change process.

23. So, when the C.O.O would run acute divisional meetings, he would performance manage the individual directors. If the Board picked up various issues, the C.O.O would be the one who would be in attendance at the Board to discuss the issue.

24. I recall attending the Board on the ACADs (Ambulatory Care and Diagnostics) project because when we built the Ambulatory Care Hospitals, they were built under PFI process. I attended the Board to discuss it because by then I had a fair bit of PFI experience.

25. In 2006 onwards when we were progressing the Ambulatory Care Hospitals, my assistant in this process was a Head of Finance (now referred to herewith as H.O.F) who attended Gateway 1 interviews in 2008.

26. Over the period the H.O.F's changed and it was a different H.O.F who attended Gateway 3 in 2010.

27. It is difficult to recall all the various meeting group titles mentioned in your files, all at different levels, as so many are still called boards. I was not on the Acute Services Strategy Board **(Bundle 30, Document 6, at Page 38).** Referring to the organogram, the C.O.O is the chair, the Head of Finance for Capital is a member and Douglas Griffin as the Board Director of Finance is also a member.

28. Then you come to the committee below that, which is the Executive Sub-Group. The H.O.F is there, and I am also a member. You will see the whole structure is overseen by a Performance Review Group.

29. The Performance Review Group is almost exclusively non-Executive directors of the NHS Board. This structure chart shows you a good governance arrangement because Board non-Executives with wide experience are represented here.

30. So, when you look and see the Performance Review Group membership, Eleanor Smith who had been the chair of the South Glasgow University Hospital Trust, is the vice chair. Andrew Robertson is the chair of the Board. Donald Sime is a staff representative. Ken Winters was a non-Executive member. Ronnie Cleland was a non-Executive member. Ian Lee was a non-Executive member with a financial background. This is almost exclusively non-Executive members of the Board.

31. Looking at that structure, what you're really seeing is the governance from the various groups feeding back up, feeding into an Executive Sub-Group, feeding into Acute Services Strategy Board, and all the way to the non-Executives, so that when it finally gets to the NHS GGC Board, the Board members and non-Executive members are not blindsided in any way. They have sat in meetings and had any detail they have wanted to ask.

32. Regarding your question about reporting lines and decisions in respect of the procurement of the hospital, how that worked and where the decision-making sat in relation to procurement and appointment, that sat under Director of Acute Planning, who was responsible for the procurement of the new Hospital directly to the Board C.E.O.

33. In 1999 when I joined South Glasgow University Hospitals Trust, Mr Calderwood had previously been responsible for building other parts of Glasgow Health Care. The Board needed to do something about the Victoria Infirmary and the Southern General and needed a site to build a new hospital in South Glasgow.

34. After the 2006 restructuring, day-to-day responsibility for rebuilding went over to Director of Acute Planning and the C.O.O had responsibility for running Acute Hospitals.

35. NHS Glasgow is a big organisation. The acute revenue budget alone was £1.5 billion. So that meant the C.O.O and the Director of Acute Planning (now referred to herewith as D.O.A.P.) had to work together. In terms of launching the procurement and business case, the OBC and the FBC and the project team, all sat very clearly under the D.O.A.P.

36. In terms of final decisions, all final decisions were taken by the NHS GGC Board, including appointments of personnel and final preferred contractors.

37. When we met to evaluate bidders leading to the appointment of Multiplex, there could have been twenty or even thirty people at these meetings. There were members of the Board there. There were advisors there. There were Acute Services people there. We had presentations, and the advisors took us through it, but eventually it was a Board appointment. Neither the Acute Services Planning nor the Acute Services division had the power to appoint someone to build the new Hospital, then keeping the Board out of it all, or not knowing what was going on. These appointments were made entirely by the Board. Board representatives were at the selection panel working through the scoring.

38. In terms of water and ventilation systems, the responsibility for that would have sat with the Director of Facilities and Project Director, on a day-to-day basis. The Project Director and his team would be the ones who would be interfacing with Multiplex. I did not have any involvement as a finance manager for ventilation.

39. The main people who would understand ventilation issues, aside from our design advisors would have been the C.O.O, the Project Director and the Director of Facilities in the Acute Division.

40. When NHS Glasgow completed the organisational staff restructure in April 2006, Argyll and Clyde was then disbanded, and staff in Argyll and Clyde were subsumed into NHS Greater Glasgow and Clyde.

41. The Chief Executive at that time had just overseen that major restructuring programme and appointment to posts. At that time, ACHB had a Director of Facilities and there was also a Director of Facilities in Glasgow (Acute).

42. Mr Seabourne then came into NHS Glasgow from Argyll and Clyde understanding facilities and was appointed as the Project Director for the new hospital.

43. As project Director, he took over the project team and was responsible to the D.O.A.P.

44. In terms of the responsibilities for the management and reduction of risk to patient safety, or from the environment, I would have thought, again, that would have to sit under the Director of Acute Planning and her team through linkages to Infection Control. We should note that the Director of Acute Planning left in February 2010 and thereafter the Project Team reported to the C.O.O.

45. An issue might then eventually come to one of those senior committees where the change would be discussed and ratified because the decision would require to instruct a change control.

46. If the original bid assumed one design which has then changed, there would eventually be a change control and a need to pay an extra amount for the revised work. That is when I would be aware, under change control.

47. Overall, the responsibility for ensuring the health and safety and patient safety sat under the Director of Acute Services Planning and latterly the C.O.O. As mentioned, the D.O.A.P left February 2010, and I think we only appointed Brookfield towards the end of 2009, as per reading The Inquiry papers.

48. So, from February 2010 onwards, the C.O.O is now in the chair responsible for the new hospital project direct to the Board C.E.O.

49. In answer to the question about where the decision-making would sit for the works to improve or remedy any deficiencies in the water and ventilation systems after the handover, I left before the handover, so I do not know what happened after that.

50. The Director of Facilities retired late 2013 I think, and I believe the Project Director also retired, I think in 2013 as well, and a new director, David Loudon, replaced both posts. So, he would have been the responsible person direct to the C.O.O.

51. In terms of any understanding I might have of any formal/informal meetings that met outside the structures, beyond these groups that we've discussed, the committees etc., I am not aware of any such formal/informal meetings that made any such decisions.

52. I would keep in touch with the Head of Finance to understand what was happening. But I could not decide anything outside of that structure because when you see it in that chart from February 2010, any change would have to come up through the various groups reporting upwards. Outwith this I am not aware of any informal committees that made project decisions. Certainly, before January 2015 I am not aware of any.

53. In terms of how it was decided which issues, decisions and reports would be escalated to the full Health Board per se, I refer to the structure of the chart **(Bundle 30, Document 6, at Page 38)**. because it all worked a similar way. This was from 2010, but before 2010 there would be different names to boards and committees. When we were building the new Maternity, then Women and Children's would have a group, and if we were building labs, laboratories would have a group in here. But, in principle, if a group had a big issue, I would expect that group and the minutes of that group to find a way back up to this Executive Sub-Group.

54. Now, if there was a change to ventilation requirements, I would expect that the Director of Facilities, the Project Director and the C.O.O would know about it. They were the people who understood technical issues along with advisors but it then would come to the Executive Sub-Group if after February 2010 where it would be discussed and minuted. This group above the Executive Sub-Group, the ASSB, would then get the minutes of that Executive Sub-Group. If before 2010, a similar process was in place.

55. That is how it would escalate. We would not discuss a large issue at one group and then not inform the Committee above about that. The minutes go up as a matter of routine, so I really do not see how that can happen in relation to any major issue.

56. If we were discussing finance and where we were financially in the project, then I would expect the Board Director of Finance to know. Frankly, I would tell him the position, but I would expect him to see that from the minutes, if discussed.

57. In terms of the Health Board, and being aware of what procedures they had in place to ensure that issues that had been raised with them were being monitored, actioned, resolved, I never sat at Health Board level so I cannot comment on specific Board monitoring procedures for this.

58. I could only talk about the Acute Division level. I know when audit issues came to the Acute Division level, then our non-Executives made sure if there was an audit issue about anything, it went on to a list and we made sure the issues were actioned before the next audit committee. That way, the non-Executives made sure issues were progressing. I would imagine those same non-Executives, and particularly Eleanor Smith when she was on the Board, would have ensured that if any issues had been made known to them, that they would have been focused on receiving updates on these and getting clarification on how their resolution was progressing..

59. But I can only talk to that up to January 2015 in terms of what happened in the Acute Division. The Board's internal procedures I cannot comment on.

60. You referred me to Dr Redding's witness statement, her comments regarding the SMT and Clinical Governance Committee taking decisions on the information discussed at the full Board, etc., I believe this was all after I had left.

61. At that time, the senior management team would have been involved in clinical governance, but the timescale reads to me about 2017 or 2018 and the whistle blower etc; I really cannot comment.

62. But if you look at the structure **(Bundle 30, Document 6, Page 36 at Page 38)** how it all worked, certainly up to 2015, it is very difficult to progress issues without any form of oversight.

63. I have been asked about my role as Director of Finance (Acute) what were the circumstances of my appointment, what the length of my tenure, my key roles and responsibilities and who I reported to and who reported to me? Looking at my role as Director of Finance (Acute) my key role was the financial support to the Chief Operating Officer for all financial targets. I was responsible for finance. The Chief Operating Officer was responsible for all divisional targets. Waiting times, for example, I was not responsible for that, but I would sit at meetings, and the Director of Medicine would update whether we've met the target or not. If the Acute Division was not meeting its targets, the responsible officer was the Chief Operating Officer, and he/she was responsible to the Chief Executive and the Board.

64. In terms of my support, it was really basically making sure there was financial breakeven within the division overall. If surgery was well overspent because of waiting times or something, I could not instruct anybody there to spend less money. I could only say there was a need to escalate this to the Chief Operating Officer. I would sit in with the Chief Operating Officer, with the director of medicine or surgery and their Head of Finance and the C.O.O could instruct them to carry out certain agreed actions. . But I could say to the C.O.O, that I did not think they are going to financially recover in Surgery or Medicine, and they forecast £100,000 overspend. However, elsewhere, we've got underspending, so if we can keep that underspending, we'll deliver a breakeven overall within the division.

65. Largely, I was monitoring and making sure that Acute Services was delivering breakeven to let the Chief Operating Officer to meet the financial targets that he was accountable for, to the Chief Executive.

66. I had a Management Accounts Division and was line manager for them. We would be running the spend profiles and such for acute services overall, and the individual acute services departments' spend. That Management Accounting team reported directly to me.

67. I have been asked upon commencing my role what stage the New South Glasgow University Hospital Project was at, what was my understanding in respect of funding for the new hospital and if any concerns were brought to my attention in respect of any financial aspects of the new hospital. I joined SGUHT in 1999 and I moved to D.O.F (Acute) in 2006, I had been involved in the building of ACADs, the 210-bed unit, and the decision to build the additional Maternity onto the existing Maternity in the Southern General site and close the Queen Mother's at Yorkhill. So, if it's from 2006, we had appointed builders for ACADs, I think, but overall, I had been in since 1999.

68. When the Acute Services Review was first launched in 1999, there was a clinical forum led by the doctors at the Victoria Infirmary and doctors at the Southern General, etc. It was clinically led at that point.

69. I think the ACADs finished about 2009, so if we're talking about a two-year build, we'd probably appointed the builder around about '06/'07. The next stage was then to progress to the new South Glasgow Hospital, and that would be about OBC stage, or the launch of OBC stage. But that also coincided with a new Scottish Government in 2007 and a change of how they were going to fund capital projects.

70. There was no mid- project change of funding from PFI to public funding. It launched under public funding.

71. Prior to this, the only way you could get new hospitals was PFI, that had been the only game in town since about 1996, possibly even earlier.

72. When SNP were elected to form a new government, it quickly became clear that they did not favour the PFI model. We were not at OBC stage at this point. You cannot launch the OBC, FBC and talk to bidders if you do not know what your funding model is going to be so, there was question on what way we were going to go. The decision to move to public funding was taken early because it's mentioned in the Gateway 1 document **(Bundle 43, Volume 2, Document 3, Page 34)**.

73. I was not involved in any way in the decision to move to public funding. This was a Scottish Government decision. We met the Capital Investment Group (now referred to herewith as C.I.G) representative Mike Baxter and I had several meetings with Mr Baxter. So, I knew that the Scottish Government was considering going the public funding route.

74. Once it was confirmed public funding, this became a great big capital project from a funding point of view. However, if we overspend, then Scotland's capital programme has a problem. Other health boards probably can't deal with the knock on from that. If we underspend, can C.I.G. move the NHS capital funding to another project and bring it forward? So, we had to have discussions, I do not know how often, maybe four times a year, with Scottish Government colleagues.

75. I was involved in these discussions. The first budget we had I think was £770 million and we progressed to £843 million because we then knew the timeframe and we knew what building inflation would be.

76. The responsibility for monitoring that spend was myself assisted by the Head of Finance Capital Planning. Over the years, because of my involvement in ACADs, I had a relationship with members of CIG, particularly Mike Baxter. So, in those meetings, I went with the Head of Finance.

77. I did not have any concerns about finance, and when I retired, it was under spent. We had to deliver to capital phasing's, obviously, because it's an annual budget, and we also had the Maternity project running and the labs project running at the same time. Overspending on these and the new hospital could affect the national budget, but the project was under spent when I retired. Financially, it was never under any problem at all.

78. In terms of your question 10, and my understanding of the resource that would be required to deliver the new hospital, and what involvement did I have at the outset of the procurement phase in outlining the resource? I was heavily involved in that. I would meet with Mike Baxter along with the H.O.F, there may have been another member or so of CIG. I am not 100 per cent sure, but certainly we had regular discussions.

79. I think we had originally a bidding profile or a cost profile probably from the design advisors, and I do remember that was £770 million but that was based on current prices at the time. When we factored in building inflation and timeframe this moved from £770 million to £843 million and we had to phase it into 2010, 2011, 2012, 2013 etc.

80. I also had involvement with the Outline Business Case. The Head of Finance for Acute Services Planning wrote the finance section and I overviewed that. So, when you see the discussion in Gateway attendees, then you'll see that I am in attendance.

81. In terms of site selection, though, the site selection was before 2006. Site selection was probably under the South Glasgow University Hospital Trust timescale and we attended many public meetings. This was part of the acute services review.

82. I think the site selection was probably 2002/2003-ish because I know the Trust dissolved in April 2004, and there were only two sites identified as suitable: one was the Southern General site and one was Cowglen. Patient pathways and Flows became the key driver in site selection. With the future closing of the Western Infirmary all in patients would flow South of the river with outpatients moving to Gartnaval. So, the Southern General site would be a better pathway for patients in West of Glasgow as well as South Glasgow.

83. They hadn't built Silverburn at the time, and we had Cowglen Hospital, which wasn't a big enough site on its own, but NHSGGC had the ability to purchase the land that is now Silverburn and could have created a big enough site. Those were the two sites identified by the Board.

84. So, the Southern General site and Cowglen were the only options suitable. But you need to remember, in the Southern General there was a Neurosciences building, an Oral Maxillofacial building on top of that, a state-of-the-art Spinal Unit, and a Maternity. So, if you ended up going to a different site, you'd have to build the exact same in both sites plus those four buildings. So, in addition to a better patient pathway, in the Govan Site it was also a financially lower cost.

85. In answer to your questions regarding the changes in the ventilation system, I have read the documents provided and I confirm I had no direct involvement in ventilation changes.

86. When I retired, I left cupboardfuls of copious notes on every meeting I ever attended. But, when I retired they did away with post that I held. I think that the person who ran the Management Accounts would have taken over responsibility for the financial input into the new hospital project. I do not know what happened to the notes, but there was nothing that happened that was not left. There would have been nothing that they did not have access to.

87. But by then, the "building" was largely complete. We hadn't had the handover, nor commissioning, but it was not like you are halfway through a project. The project was, whatever the term is, almost complete.

88. The purpose of the acute services review was, to my understanding, that we had to rebuild acute services in Glasgow. We had a lot of old hospitals, particularly in the South. There was also the new Princess Royal Maternity being built in the North as well as other upgrades happening in the North. So, the strategy was to create one big site in South Glasgow and have the benefits of all of that in the South. The Victoria Hospital building was a Victorian building, and we had now signed up and were building a new Victoria ACAD.

89. To explain, ACAD's (ambulatory care) basically, if you went in and out in a day, whether it be for a scope, outpatient, x-ray or anything else, then you went to the Victoria ACAD. There were no inpatient beds in the Victoria ACAD.

90. So, inpatient services had to be rebuilt in South Glasgow, and that was the ASR launch and a decision on where it was going to be, but NHSGGC needed the two ambulatory care hospitals first. There were also issues with the Western and Gartnavel because, again, the Western was an old hospital. Although that was not situated in the South, the building of a new hospital in Govan would transfer patient flows to this hospital. Eventually the Western was sold, and the aim was to sell Yorkhill also. I think for a period Yorkhill was acting as an outpatient for adults in the West. I do not know what it is now.

91. I have noted alongside your question about ASR that I had a finance input into the ASR from the early clinical forum days. This is because from when I arrived in 1999, there were meetings with the Victoria Infirmary and Southern General staff.

92. Both John Connachen and Robert Calderwood had many a year working together because they were both based in the south of Glasgow. The Chief Executive in the Victoria Infirmary and the CEO in Southern General eventually became one CEO when John Connachen went to Scottish Government and Mr Calderwood took over the two Hospitals in 1998.

93. I have been asked about my role on the Acute Services Review (ASR) Programme Board, who else sat on the ASR Programme Board, how the membership was decided, what the remit of the ASR Programme Board, to whom did it report and what processes were in place in terms of decision making. I did sit on the Acute Services Review Programme Board. Referring to your Bundle 30, and the Programme Board meeting, Monday, 8 June 2009, as you can see, numerous senior individuals are involved in that meeting.

94. The Board Director of Finance is also a member. There's myself, the Chief Operating Officer and director of Acute Services Planning and numerous others. Director of Acute Planning was responsible for the progress in the project, and the C.O.O obviously is operational.

95. My role was to have the operational input into overall capital for the project so I would have been there talking about finance. So, you can see who else is there. We get an update from Director of Facilities on ambulatory care hospitals. Stobhill opens in four weeks, Victoria is about to open. They also talk about the Maternity strategy. So, that's the new Maternity coming into South Glasgow, so, Director of Women and Children is there. Also, the new Glasgow Hospital's laboratory. So, ASR programme board is bringing together the Maternity, the labs, where we are in the various projects, and that's why you have so many people here, including IT, including staff side, including communications. Basically, anybody who had anything to do with any of the new buildings going up in Glasgow at a senior level, if you look at attendees, would be in there.

96. As to how membership of this Board was decided I have no idea. I'd imagine it was D.O.A.P and the C.O.O, Mr Crombie, just to pick somebody from the names, was the director of Diagnostics. Diagnostics also took care of labs. He would have been there to say what was happening with the lab project. Ms Crocket was the Woman and Children's Director, so she is there updating on what was happening with the new Maternity and things like that. Sharon Adamson was the head of Planning. So, this included bed models and where we are going with targets and things like that. You have also got doctors' input. The medical director has apologised for that meeting, Audit Scotland is mentioned, director of HR from the Board has apologised. It's really Board members, Acute members, Planning members, all attended that group. So, it was really an update on where the various projects were.

97. In terms of decision making by this Board, recommendations from this Board would eventually go to the NHSGGC Board.

98. You will see that there are NHSGGC Board members there. As I say, the Director of Finance is a Board member. Mr Reid is the Board director of HR. So, there were Board members present. So, again, governance-wise, if a decision was made at this level, it is inconceivable that it would not find its way back to the NHSGGC Board.

99. I have been referred to **Bundle 30, Document 3, Page 26**, a minute of the ASR Programme Board Meeting of 8th June 2009. The minute notes that there was some discussion around the scoring system for the bidders and it was decided that A Seabourne and P Gallagher would require to have further discussion to clarify the criteria. I have been asked what was the scoring system in respect of the competitive dialogue and what was my involvement in the process.

100. You asked me if I can recall anything about that and what the scoring system was in respect of the competitive dialogue? I can as follows:

101. Firstly, in terms of a minute, it says little. “There was some discussion around the scoring system”.

102. So, the Head of Finance would have been the person on a day-to-day interface re finance with the Project Director. Before we go to meetings, any meetings, you get the previous minutes and you get the agenda. I’d read through the papers to see if there was an action for me and then look through the agenda.

103. I do remember that one because I remember sitting and thinking, “Why is that here? How am not sighted on it?”. I think the Project Director may have raised it under A.O.C.B., but it may have been an agenda item.

104. The reason it is such a short minute is I believe I suggested that the Project Director and I take that away and discuss it. I had been through ACADS and I had been through the Hairmyres Hospital, both of which were PFI, and been involved in previous scoring systems. Those mechanisms had been devised by professional advisors.

105. I met Mr Seabourne and we agreed to pass this to our advisors to produce the scoring system. We had financial advisors, design advisors and legal advisors and they created the scoring system that was then utilised.

106. The advisors had much more experience in creating a scoring system.

107. So, it was passed to the advisors to create this selection matrix and they led us through the selection process.

108. Currie and Brown were certainly one of the design advisors. I think there may have been another technical advisor, I can't remember. I believe the financial advisors were Ernst & Young. I was involved in ACADs and other PFIs and I am trying to remember which financial advisor was which. I am sure it was Ernst & Young who were financial advisors in the new hospital project.

109. I have been asked to refer to the Terms of Reference of the Acute Strategy Board Executive Sub-Group **(Bundle 30, Document 6, Page 36).** I have been asked what the purpose of this Group was and how was the membership agreed. I think you are referring to the Acute Services Strategy Board Executive Sub-Group **(Bundle 30, Document 6, at Page 41).**

110. This was basically the group who oversaw day-to-day delivery of the project. When you look at the Performance Review Group, the top Board that you're seeing on that chart, it's all non-Executives of NHSGGC. The next group A.S.S.B has some non-Executives, plus the C.O.O, the Project Director, the Board's Finance Director, the Head of Finance etc. So, that's a sort of higher-up group to the Executive Sub-Group.

111. So, the day-to-day interface between the project team and the builder would feed through some of these design groups and lab groups, etc. The C.O.O was the one who's now responsible for delivering the whole project because the Director of Acute Planning has now left. That Executive Sub-Group basically had to oversee various operational groups below. So, Women and Children's is there, the laboratory's in there. The new children's hospital is in there, and then there is design groups and a project team. The project team would be interfacing day-to-day with the builders, etc.

112. Basically, the Executive Sub-Group would allow decisions to be made to keep the project moving. However, if you look at the remit of the Strategy Board, which is the one above that, it was, "To ensure financial control is managed and kept within agreed parameters." It's the third bottom bullet point.

113. So, ASSB was responsible for overall financial control. Also, if you look at the fifth bullet point, "To approve change control in that any change that impacts upon the project must be authorised by this Board."

114. Albeit it says the Executive Sub-Group had delegated authority, the Terms of Reference state delegated authority within SFIs (Standard Financial Instructions). The Executive Sub-Group could not just go and commit another £30 million cost, because approved change, if it impacts on the project, must go to the ASSB above it.

115. So, this was largely the interface of all the groups coming together. If the C.O.O then had a problem with something slipping or whatever else, he/she was also on the ASSB above it. If Women and Children's had a problem, the Director of Women and Children is on the ASSB also above it. If it was labs, then it would feed in here, too.

116. Then it all fed up to the Acute Services Strategy Board. If you look at the remit of the ASSB, they are the ones who basically “monitor all aspects of performance and implementation, approve change control, ensure financial control, approve and monitor appropriate governance, and approve the full business case.”

117. So ASSB was the board that gave the final approvals but below that somebody has to ensure the project was progressing.

118. Going back to the Acute Services Strategy Board Executive Sub-Group **(Bundle 30, Document 6, at Page 41)**, the Terms of Reference of this group says it has “delegated authority to make decisions on project issues to maintain the programme.”

119. The Chief Operating Officer, who also sat on the ASSB above that, had the authority to say, “Yes, that is a decision”. So, if the ASSB is not meeting above for a month, for the argument’s sake, but actually the project needed the decision today, then the C.O.O had the ability to make that decision, within the Executive Sub-Group.

120. But because the C.O.O is on the ASSB above it, if it were a big issue, the C.O.O would clearly be reporting that back or talking to the Chief Executive about it.

121. But it might be something really small. So, it is a decision that can be made to maintain the programme. If anything was going to threaten the programme, the C.O.O had to make sure that was dealt with.

122. But if the C.O.O needed further assistance or approvals, the C.O.O is talking to the Chief Executive or he is talking to the members of the ASSB above that.

123. So, to answer your question about context, what sort of decisions were the Executive Sub-Group making? It was largely where the Chief Operating Officer thought it was within his/her delegation for these decisions to be taken and approved by the ASSBESG.

124. I do not think there were major financial issues here because finance was never really threatened in this project.

125. So, if there was something requiring attention or they had to move a door from here to there, the C.O.O would have had authority to make that decision. I can't recall in any of the meetings that we made a major decision that would not have then progressed to the ASSB.

126. And I think the Project Director would be describing the issue. So, the C.O.O and Project Director would know exactly what the issue is and both of those sat on the ASSB also. I do not recall any major changes which the Executive Sub-Group took that would not have progressed to ASSB also.

127. This was meeting weekly. The Executive Sub-Group was meeting weekly, and the Strategy Board was meeting bi-monthly.

128. With the executive sub-group, the Terms of Reference say that the executive sub-group could "exercise delegated authority to commit funding for new or additional works associated with the project."

129. And then the last bullet point says, "Within the Board's SFIs", which is an agreed delegated limit. So, the Executive Sub-Group could not bring in major change without ASSB approval.

130. Again, from a finance point of view, I do not recall many major issues, but if there was an issue coming up in the project team, they had access to this group to update what those issues were. If it was a large issue, then it clearly would go to the groups and Board above. But in between times, I would have expected the Chief Operating Officer to be talking to the Chief Executive or other seniors if there were a major issue affecting the programme. But I do not recall many major changes and any change control from a finance point, would have come to the Executive Sub-Group on a spreadsheet and that would have been approved either at Sub-Group or ASSB level, depending on the value.

131. So, albeit the Executive Sub-Group can make decisions, these must be within the Board's Standard Financial Instructions.

132. Regarding the ventilation derogation, I have reviewed the few pages sent to me, together with Mr Seabourne's email of the 23rd June 2016. I have also considered question 33 where Currie and Brown state to the Inquiry, that the project team had advised myself, Helen Byrne and Alex McIntyre of the agreed ventilation derogation.

133. Mr Seabourne's email notes that a key issue was that facilities specified the building could not rise in temperature above 26 degrees in the summer months (not usual). He also notes this had been problematic with the new ACADS.

134. The Ward ventilation design strategy paper from Currie and Brown in December 2009 starts with a Board requirement that the summertime temperature limit is "Not to exceed 26 degrees for more than 50 hours per year".

135. So, taking both documents into consideration it looks like a facilities specification on temperature requirements drove the change in the ventilation strategy to a Board requirement.

136. With regard to Currie and Brown's view that the project team advised myself, Helen Byrne and Alex McIntyre of the ventilation derogation, I have no papers here to review that. That said, I would expect Mr Seabourne to write to Helen Byrne (his Boss) Mr McIntyre as Director of Facilities who had apparently specified that change and myself to potentially expect an additional cost. I would confirm that I would have had no involvement in the ventilation derogation other than noting financial consequences.

137. Following on from this, any costs would go forward on the Change Control spreadsheet to the appropriate groups. Had it had a major finance input, I would have been involved in discussion, but I would need to see more papers on this particular topic. All I have really seen is what you have provided me.

138. This change looks to have preceded the Executive Sub-Group, where one of its Terms of Reference is, “Receiving reports from acute director and Project Director and changes being proposed with financial implications. The structure before 2010 would have been similar but I do not recall any reports or changes that threatened the project cost or timetable. However, any change that had a finance implication was kept in a spreadsheet by the Project Director and brought to the appropriate senior group at that time. So, I would expect ventilation derogation to have been raised and discussed.

139. So, as noted, when and where changes had been agreed or proposed, the Project Director would have brought to a senior group. There was a running spreadsheet detailing additional costs incurred. So, the Change Control spreadsheet that was maintained by the project team was updated for Executive Sub-Group’s approval, and the appropriate groups before 2010.

140. Next is question 19, Gateway Review process and any involvement I had with it. The Gateway Review was basically the Scottish Government’s governance arm. I think Gateway 1 was in January 2008. At that first one, I do not think we had launched OBC at that point. When the Board, the Health Board approves the OBC or FBC, they need to know good governance is in place. There is no point in the Board approving a project and the Gateway Review, then publishing next week stating that it had poor governance.

141. So, I think before the NHS Board approved the OBC/FBC, we had a few Gateway meetings, and then the fact that you get a good report, this fed back to the Board to say, from the Scottish Government point of view, governance is working well. Everything is in place. Financially, it is also within all the right levels so the NHS Board were able to approve OBC/FBC following good Gateway reviews.

142. It was really part of the governance process to go through, and also to let the Scottish Government know exactly where we were, what our timescales were and what our costs were.

143. I was one of the attendees at Gateway reviews. It all happened over a couple of days, and I recall discussions around the funding model, but what else we discussed there, I do not recall other than what they have written.

144. It was quite key that we got a decision following Gateway 1 on the procurement funding route. Had it been PFI, similar to ACAD's procurement, then we would have to have started and done whatever else was required. But if it is public funding, then it is a different route for the design group and the rest.

145. During the Gateway Review 1, I would have overseen the Head of Finance for Acute Planning for that interview. They would have written the finance section, and I would have overseen and been involved in that and have final review of it.

146. In general principle, my role would have been making sure the finance section was there. The Gateway 1 review input was led by the Director of Acute Planning.

147. The Director of Acute Planning would have been the person responsible for pulling that together, and within that, different parts of the group would be doing the finance section or the bed model or whatever else. We would all have been doing relevant sections and feeding back up through the D.O.A.P.

148. So, Gateway input goes up through the Acute Planning side. This included a finance section, and I was involved in that.

149. In terms of going to the NHSGGC Board for approval and then submitting it to the Capital Investment Group, firstly, it would have gone through Gateway because Gateway was the governance sign off that the project was in a fit state.

150. The principle is that would be your governance approval.

151. This allowed the Health Board to know that at committee level it is looking good, that the Government's governance arm is looking good and CIG would be feeding into that.

152. I interfaced with the Board's Director of Finance as required. He was the one who sat on all the NHS board meetings and, therefore, decision-making would have sat with, from a finance point, the Board's Director of Finance because ultimately it is at board level where approvals are made.

153. Regarding the extent of the dialogue with the Capital Investment Group and with the Scottish Government regarding the outline business case, I met with Mike Baxter and one or two members of CIG now and again, not about that *per se*, but largely about the funding model and how much we needed, but not the various sections in the business case.

154. You asked me about the Gateway Review, at 5.2. Gateway Review 1 states: "One major challenge to the project is the impact of the chosen procurement route. Early drafts of the OBC were predicated on a PFI procurement route. However, because of issues about affordability and a change of emphasis on alternative procurement options by the new government, a wider selection of procurement possibilities has been considered."

155. I agree that clarity on the funding route was required at that time. We had not started. We were at OBC stage. I am sure the SNP led government were elected, about June 2007. It was about then, and this was now January 2008. We have, somewhere around about that time, financially closed two ACADs, so we are moving on to the new hospital, but there are obviously sound bites that it might be going the public funding route. Well, we cannot do an OBC or an FBC without knowing the funding route.

156. The public funding route certainly cut down my involvement with lawyers quite a lot, because I do remember in the ACADs, and particularly the Hairmyres hospital, that there were acres of lawyers when you sat down, reading contractual changes. I did not see any of that in the public funding route. By going the public funding route, it is just a great big capital project, from a finance point.

157. I think it got easier, personally, but that is from a finance point of view. There were a lot less legal meetings regarding contract monitoring, second period pricing formula etc. But the funding route did not change during this project. That is the point I am making. PFI had been there for about 10 or 12 years or more. We had built other buildings in PFI in the South and assumed we were doing PFI in this project. So, in the early iterations we had thought because that was the funding route for the NHS, it would be remain the same. But we had not launched the project under PFI but rather, required clarity on the funding route before moving forward.

158. As to the next question, which is question 22 in respect of the Gateway Review 3, which was in October 2010, I am listed as one of the interviewees. I attended Gateway a couple times. It was just at this point the project team were in the final stages of completing the Full Business Case for Gateway Review 3.

159. The process lay, with the daily responsibility of the project team, under the Project Director. By then, the Chief Operating Officer, who took over after D.O.A.P left in February 2010, and this is October 2010, is leading the project. The process for leading that below the C.O.O would be with the Project Director and the project team.

160. The appropriate sections of the FBC were the responsibility of each directorate, where appropriate, so for example, the sections for Children and labs – I cannot remember if that is mentioned there – would have lain with them. The finance section was under my lead.

161. I had a similar role at the Outline Business Case as to when we did the Full Business Case.

162. It would be a similar process for gaining the full Board approval as with OBC, and then onwards to the Capital Investment Group.

163. So, again, from memory, gaining the NHS Board approval would've seen the FBC pass through the Acute Services Strategy Board, logically, to the Performance Review Group, because that is now the reporting structure.

164. From then, it would have gone up to the Board for approval, but I think after approval it would go to the CIG. But before that Board approval, I think, the Board need to know that the Scottish Government is happy with the FBC. .

165. In all, the final sign off on the Full Business Case would have been the NHSGGC Board. They are launching the project.

166. Regarding the Gateway Review 3 at paragraph 4.41, headed, "The Review of the Current Phase" where it states, third line down: "The review team found that both client and contractor staff acknowledged that the competitive dialogue period was shorter than typically found."

167. I have no real comment on the length of the CD (Competitive Dialogue) process. I suppose Gateway are seeing many projects and the Gateway teams will know how long they took, but this was a big project. Should it be longer? Have they done others? Or for the previous 10 years or so, Gateway has been reviewing PFI contracts, and whilst they are saying "typically", I do not know if that is a reasonable comparison.

168. I could not have told you whether it was 3 months, 9 months or 15 months or whatever. But I had no concerns about it at the time.

169. When you read on, you can see it was four months, and the Gateway team then say it is because of “contributing factors, a high quality of detail design, a high structured plan meeting and informing bidders.” It then says, “This project should capture the key points of procurement in a case study and share across the public sector.”

170. So, if you read the paragraph, you may ask, “why is it so short?”, but if you read the whole section, it states that “this approach has been highly effective and efficient”, so overall an excellent report.

171. When I was interviewed for Gateway Review 3, my input would have been the finance section and describing the affordability plan. That sort of thing. I do not specifically recall it, but I cannot see it can be anything other.

172. To bring it all together, as we were progressing OBC, we were really wondering which procurement route we would follow, but by the time we get to FBC and launch it, we know it is a public funding model.

173. I have been asked what impact, if any, did the change from the PFI model to public financing have on the overall delivery of services or the overall design and construction of the hospital. I have also been asked if there were any risks or resource implications as a result of the change from PFI to a public funding model, particularly in respect of commissioning, independent validation and resources. Again, please note it was public funded from the start. Early Gateway had mentioned this and there was no change to the funding model throughout the project.

174. I cannot comment on commissioning. I was not there. The impact of independent validation – again, I have no comment. I was not there. The affordability model was based on the public funding model, and we had already detailed the resources to manage and maintain affordability.

175. If you were closing, for argument's sake, the Victoria Infirmary, if we take facilities as an example, then there would be so many domestic staff, maintenance staff and whatever else. Equally, closing the labs in the Southern General and the Victoria Infirmary, then the appropriate directors came up with new staffing models, et al. as to what their new costs would be within the new hospital.

176. By adding that all up, we had an affordability model. We also knew what the capital charge would be, so there was no financial challenge based on the affordability plan.

177. In terms of all matters commissioning, I was away before the hospital was commissioned. At no point were any concerns brought to my attention in respect of funding. When I retired, the project was underspent. I do not know what other costs were incurred after that, but the building was nearing handover, so I suspect very few.

178. I have been asked about the process for requesting funding, who was responsible for submitting applications and who was responsible for approving them, and whether any specialist input was required to advise on application before they were submitted or approved.

179. When we commenced the QEUH project, the decision was made that some specialties were not included in the transfer to the Govan site.

180. We had agreed a bed model. We had agreed the number of consulting rooms, theatres, A&E spaces etc, and probably by 2013 that was it, it was all designed and was seen as a potential centre of excellence.

181. You could not put another floor on. The helipad was obviously going up there. So, by that point no major construction change was likely.

182. So, unless there were major changes for theatres for example, I would not have seen a significant finance cost in there, and I do not recall any of that, so I do

not know what question 27 paragraph 174 above means. My answer is once we had agreed the cost profile with Scottish Government, we knew how much money we had.

183. Where an internal cost arose that came back to the change control spreadsheet. The Project Director and his team would then have brought that as a cost, back up through the design group, to the Executive Sub-Group, to the ASSB all the way up. If it was a required change, then the Executive Sub-Group, largely led by people who knew whether it was appropriate, it would be discussed and approved at that group.

184. They would agree it. But, again, remember the Acute Services Strategy Board had to agree all major change control so governance was strong here.

185. The Acute Services Strategy Board also had the Performance Review Group above it. So, in theory, it would flow up through these groups.

186. If it was a much smaller change, then the Executive Sub-Group could just approve it and ratify this at the A.S.S.B later in order to keep the project moving.

187. Question 28 is about my role in ensuring the project remained on budget and on schedule. I had a role in looking at the reporting and the financial managing of the overall QUEH project and the Glasgow capital spend, because we had lots of other capital projects going on also within NHSGGC capital programme, so I would overview that.

188. The new hospital, if it was staying on spend profile, the likelihood is our other projects were going to be okay. However, if it was coming off profile then that could affect the whole NHS Scottish national programme due to the size of the project. However, we were never off programme.

189. If at the year-end we were going to have slippage, we were updating CIG. They would then consider how to move this and ensure we get that back next year. So, we had that interface, but I do not recall any large issues as such.

190. I have been asked about the Scottish Government oversight on the project, particularly the CIG in respect of financial decisions taken in respect of the project. The CIG approved the capital costs and their profile. This was required for the national programme.

191. We met regularly with the Scottish Government representative Mike Baxter on this group.

192. The other part of that question was who did I report to? I reported to the Chief Operating Officer.

193. The final bit of that question is what level of scrutiny was given by CIG in respect of financial decisions? The annual capital budget agreement on spend profiles was approved by CIG. Updates on actual spend went to CIG on a monthly basis. This included Glasgow capital spend on all projects, including the new hospital.

194. So, CIG are getting a monthly capital report for where Glasgow is as you progress. Invariably, there is slow spend at the start of the year and higher spends in March, but they need to see spend profiles.

195. So, there were interfaces and our Capital Accounting Head of Finance would update on spend profiles. So, CIG received monthly reports on all capital spend.

196. The capital accounting Head of Finance reported on all capital spend within Glasgow. He overviewed the capital programme in finance terms and reported to myself. I would take the HOF to all meetings with the CIG representative.

197. I have been asked if I had any involvement in respect of the appointment of Currie and Brown as technical advisors. From memory, I had no involvement in the appointment of Currie & Brown.

198. You asked me about my understanding and involvement in respect of the selection process whereby Multiplex was selected as the preferred bidder. As detailed earlier, once we had the scoring mechanism created by the advisors and once we had all presentations, I was a member of the group that recommended the NHS Board appointment of this builder.

199. I think we met in various places over the period. The group had Board representatives, Acute Division representatives, medical representatives etc. There were also advisors there who led us through the process.

200. My recollection is it was quite a detailed scoring mechanism and Currie & Brown, because you mentioned them, were the design advisors. I think there were other technical advisors on fixtures and fittings and pipework etc., but I am not quite sure.

201. The advisors created a Scoring Matrix that considered the quality of the building and the use of materials, the concrete or anything like that. The technical chaps took us through the technical side of things and then the finance advisors took us through the bids from the bidders. Then twenty, thirty or forty people, listened to that, scored the various bidders, and I think it was Ernst & Young financial advisors took ownership of it all, and presumably did minutes. The scoring sheets came up with a score and Multiplex were appointed by the NHS Board. That is as I recall it.

202. Multiplex would have then been awarded the contract by the NHS Board following the competitive dialogue process based on the scoring mechanisms,

203. I was a member of the evaluation group that included the scoring outcome. Multiplex were appointed following the outcome of that scoring profile.

204. The scoring outcomes were retained, I believe, by the financial advisors and that will detail the Multiplex scores against other bidders.

205. So, access to the scoring sheets will probably show that some of the bidders scored more for the non-technical side or the technical side and some scored less, and when you look at them all together Multiplex were recommended because they had the best score. That is how I would recall it.

206. The NHSGGC Board would need a scoring outcome to then appoint them, so there must be a minute somewhere because it was a Board appointment. There were Board members at the scoring event. I would not have seen other scoring sheets other than my own. I do not think we even left there with any papers. I am pretty sure they all went in. This would be late 2009. That is as I recollect it from about 15 years ago.

207. I have been asked about my understanding of the ventilation derogation at the Queen Elizabeth University Hospital. I have no specific recollection on major discussions on the issue but as noted I would have seen any financial cost implication.

208. I have read the paper on Ward Ventilation Design Strategy. Whilst I do not recall particular discussions around the paper at our usual committees, the footer notes it as a Currie & Brown document from December 2009. So, it is possible the design advisors brought this to the evaluation day to take members through any design issue. Other than that, I have nothing to offer on the ventilation issue.

209. I have been asked about changes made to the maximum temperature variant. As noted in paragraph 132 it would appear a facilities requirement due to ACAD temperature problems drove the change.

210. I would not have been involved in specifying a change to the maximum temperature variant.

211. Overall, though, I am unable to comment on ventilation or BREEAM.

212. Overall, in terms of Question 36, the responsibility for approving the ventilation strategy would have started at the Project Team or Facilities level and worked its way through the appropriate groups.

213. I would not expect a change to an SHTM without discussion at a senior project group.

214. I think, given it was before new arrangements in February 2010, it would likely have had to come to Acute Services Review Program Board via the Director of Acute Planning or Director of Facilities. The way governance works, if there had been discussion it would have to have started its route in the project and then it would have had to have gone up through the appropriate groups.

215. I would have thought it would find its way to the Acute Services Program Board for discussion.

216. If this necessitated a large finance change, then it should have been discussed at an ASR Program Board. Equally if there is no finance change, or there is a small finance change, I would have been involved in a finance change control.

217. In response to your question about SHTM guidance, I knew there were standards to be met, but I do not recall specific discussions about the ventilation strategy paper.

218. In terms of there being a drive for cost efficiency during the build; we had an affordability profile. There is always a drive for cost efficiencies. But, when we launched FBC, we obviously could not launch without knowing that we could afford it.

219. We had the capital cost which was now public funded, and that brought a capital charge as opposed to being exposed to the market at completion on the volatility of interest rates.

220. Each director set their workforce profiles, so the director of nursing, for example, had detailed what the nursing profile would be in each ward within the new hospital, and the Director of Facilities had detailed how many porters, maintenance staff and domestics were required, and that built up against what we were saving in the other hospitals. Once we had that affordability profile, there was no further push required.

221. It would always be reviewed annually with new budgets etc, and then, getting nearer the hospital opening, you would need to then review it again. But the requirements were signed off. For example, the nurse director signed that she could manage with the agreed nursing profile.

222. In terms of energy efficiency, I think the Director of Facilities would be clear on what energy saving we would expect. A lot of the old Southern General infrastructure was energy inefficient. So, there was energy saving. There were other savings that created the affordability profile.

223. Just to clarify, when I say this was always being reviewed, what I mean is, for example, if we suddenly said we required more than £843 million, or the Treasury increased the capital charge percentage and, therefore, there was going to be an additional cost to the project, then we would need to consider what additional savings we could make. You would always keep an eye on it as you go through the project. We had an affordability profile and we had a capital budget that allowed us to build and run the hospital and, broadly, that was it.

224. Again, there was no drive for cost efficiency against the needs for patient safety. Certainly not in the models before 2014/15. There was no trade-off for cost efficiencies against patient safety. That just did not happen.

225. At the point I retired, I had no concerns about the financial profile for the hospital opening. As to the building itself, it would have been whoever was involved in commissioning and the technical individuals as to whether they were ready for opening.

226. I had absolutely no involvement in handover commissioning, validation, Infection Prevention Control, or commissioning validation. I wouldn't have been involved in any of the commissioning, completion certificates or contractual compliance.

227. Regarding Section J, the New South Glasgow Hospital Executive Board, question 52. This is May 2008. I do not see the document referred to in the papers I have been sent. I do not recall this Board without seeing the document. However, it is likely I was a member and this would have been an early iteration of the later Executive Sub-Group etc.

228. There are so many of these groups over the years. I do not recognise the name of the Hospitals Executive Board. I suspect the remit was not majorly different to where you end up later with another group, the Acute Services Strategy Board or the Executive Sub-Group.

229. In the ASR programme Board meeting in June 2009 there is listed myself and the Board D.O.F, and the members of that group at that time, including Brian Cowan. He is the Medical Director. Whereas, later on in February 2010, you have got the HOF and Board DOF in that Acute Services Strategy Board meeting. You have got Director of Women & Childrens so I suspect the NSGHEB in 2008 was an earlier version of the Acute Services Strategy Board or Executive Sub-Group from February 2010.

230. I believe that with the Director of Acute Planning leaving, that forced a review of the various groups and the creation of this structure because it was all coming back under the C.O.O. So, I think the remits would be broadly similar with the addition that the appointment of a builder required additional interfaces and governance approvals.

231. Regarding the Performance Review Group as detailed in the new governance structures in February 2010, you will find that all of those members are non-Executives of the Board. Therefore, I am not a member of this PRG. However, there could have been a Performance Review Group back in 2008, but again I do not have papers detailing this group or remit etc.

232. It is the titles that are difficult to recall. I sat on lots of groups over the years of the project. So, if it is the Performance Review Group as depicted in the 2010 February paper, then I was not a member. But if, in 2008, there was something else called a Performance Review Group, I may well have been a member. But the remits of these groups and the roles of these groups would have been created by the Director of Acute Planning. If it ran from 2006 to 2009, the D.O.A.P would have been the one that created the remits et al., and I would probably have sat on some of those groups.

233. A lot of groups are called “Board”, but this should not be confused with NHSGGC Board, who had ultimate authority on decisions and other appointments. But these other Boards are other operational groups.

234. I have been referred to **Bundle 30, Document 6, at Page 50**, regarding the Project Steering Group. I do not see this group in the new structures, but I suspect remit etc. would have been an earlier iteration of February 2010 structure.

235. Gateway reviewed all this in January 2008. I am not sure of the year for this Project Steering Group though I suspect it was overseeing the project until 2009.

236. Given this is before OBC, my role in this group would have been what is happening generally in the project, what are going to be the financial consequences etc.

237. I think the D.O.A.P joined in 2006 because that was the restructure period. She had a Head of Finance appointed to her, who worked for her for a period of about 18 months. That person would have been responsible for the early finance progress towards OBC and I would have overviewed this, but we didn't get there until 2008 and we have already picked up my involvement in the OBC.

238. Regarding the New South Glasgow Hospital's Laboratory Project Executive Group, I think this again is an early development, of how the structures worked between 2006 up to when we get to Gateway 1 in January 2008. This preceded the structures detailed in February 2010.

239. I think this was the structure for the build of a new laboratory so a project board to overview this build was required.

240. So, in addition to laboratory specialists there would be a need for a financial representative, facilities representative etc.

241. The likelihood is if it was covering the New South Glasgow Hospitals and Laboratory and I was at a senior level as the acute Director of Finance, I would have sat on that group. But it would have been the first go at a structure as the project develops. So that would be in about 2006 to 2009 or so.

242. In response to your final question on whether there is anything else I'd like to share with the Inquiry and whether I thought the project had been a success I'd offer the following.

243. I think in terms of the final output the Acute Services Review was a success. The ASR set out to replace old hospital facilities across Glasgow. We now have new Ambulatory Care Hospitals in Stobhill and Victoria, a new Beatson Cancer

hospital on the Gartnavel site, a new Children's Hospital and Maternity Unit on the QEUH site , transferred from Yorkhill, and a 1000 bed, single room , modern hospital in the shape of the QEUH. The old infrastructure of Western Infirmary, Yorkhill, Victoria Infirmary, Stobhill Hospital and the Southern General Hospital have all been replaced. So, the ASR achieved what it set out to do.

244. Wearing my finance hat, all of the above was achieved within financial budgets. Other major Scottish projects in Edinburgh Trams, Scottish Parliament and presently Ferries, have not delivered within the financial budgets allocated. So again a positive outcome here.

245. I think at times there were too many meetings, but that is largely what happens in a large project of this size. But the output is there in the shape of modern health facilities as detailed above.

246. Over the last few years, I have taken my 93 year old father to the QEUH, re his healthcare, on numerous occasions. The relevant departments are in close proximity and easily accessible for him.

247. Five of my grandchildren have been born in the new maternity facility since 2011. My children, grandchildren, my wife and I all access QEUH when required. So, from a personal healthcare interface I have found the QEUH to be an excellent hospital.

248. Overall, I do believe the project was a success and the ASR achieved what it set out to do. .

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.

Signature……. Date…….

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

Appendix A

A47390519 - Bundle 11 - Water Safety Group (External Version)
A47069198 - Bundle 12 - Estates Communications
A48890718 - Bundle 13 - Additional Minutes Bundle (AICC/BICC etc)
A47851278 - Bundle 16 - Ventilation PPP
A48235836 - Bundle 18, Volume 1 - Documents referred to in the expert report of Dr J.T. Walker
A51598597 - Bundle 30 - Acute Services Review Papers
A35503139 – Bundle 30 – Acute Services Review Papers
A33998289 – Bundle 43, Volume 2 – Miscellaneous Documents
A33998293 – Bundle 43, Volume 2 – Miscellaneous Documents
A35422674 – Bundle 52, Volume 2 – Miscellaneous Documents
A49847577 - Hearing Commencing 19 August 2024 - Witness Bundle, Volume 3
A47711392 - Hearing Commencing 19 August 2024 – Witness Bundle, Volume 7
A49223572 - Hearing Commencing 19 August 2024 – Witness Bundle, Volume 7