SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
16 September 2025

Day 14
8 October 2025
Julie Critchley

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10:03

THE CHAIR: Good morning. Now, Mr Connal, we have Ms Critchley today.

MR CONNAL: Indeed, my Lord.

THE CHAIR: Good morning, Ms Critchley. Now, as you understand, and of course you've been with us before, you're about to be asked questions by Mr Connal. Before then, I understand you're prepared to affirm.

MS CRITCHLEY: I am.

Ms Julie Critchley
Affirmed

THE CHAIR: Now, as no doubt I said on the last occasion, we have you scheduled today for probably the best part of the day. We'll take a coffee break at about half past eleven, but if you want to take a break at any other time, just give me an indication and I do appreciate that it's difficult to remember to do this, but could I ask you to speak maybe a little louder, maybe a little slower than you would in normal conversation? It's important that we all hear what you have to say, and my hearing is not what it was. Now, Mr. Connal.

MR CONNAL: Thank you, my Lord.

Questioned by Mr Connal

Q Good morning, Ms Critchley.

A Morning.

Q I'm going to start by asking you the question I always ask witnesses at this stage which is, for this effect, you've produced a witness statement; in your case a witness statement with appendices for the Inquiry. Are you content to adopt that statement as part of your evidence?

A I am.

Q Thank you. Your background is set out in your witness statement which we'll bring up on screen and we'll use the witness statement as a sort of guide to take us through the issues. As you know by now, when the witness statement comes up on screen, we'll have electronic page numbers at the top.

Now, I'll probably get into the habit of using these but if at any time you're not sure where I'm going just let me know. The early part of your statement you set out, as is customary, who you are and in particular for our purposes you are the director of NSS Assure.

A I am.

Q And you've been in that post since September 2021, NSS Assure being essentially a new organisation which we'll come to in due course. Immediately prior to that, you held a post south of the border.

A I did.

Q With another health body.

A Yes.

Q And on page 214, in the first large paragraph, you describe yourself in your post as having the lead for the healthcare built environment in NHS Scotland, is that right? That's how you would sum it up.

A Yes.

Q Thank you, and you have responsibility for the strategic direction and delivery of the directorate, which is NHSS Assure. Now, I'm conscious, and there's no issue about this, that you may have been asked from time to time during the preparation of your witness statement questions that you needed to get information on from others within NHS Assure, and you've indicated that at various points during your statement.

Now, by sort of slightly reverse direction, I just want to pick up on one of the documents you produced. On page 214, you're asked about an outbreak in April 2021 of Serratia. That was, of course, at a point before you were in post.

A It was.

Q And you point out on page 215 that one of your colleagues was involved. Now, you say on page 215 that reporting systems have been included in the National Infection Prevention Control Manual since 2016.

A That's correct.

Q And what you then go on to produce as part of your witness statement is an appendix, Appendix D, which, as you say, contains all of the changes made to that publication since 2012.

Now, on my notes, my Lord, that runs from page 290 to page 407 of the document in electronic terms that we have in front of us, and my Lord will be relieved to know I don't intend to go through that, but can you just help me understand in what way you think having that available to the Inquiry might be of assistance?

A I think it was just to demonstrate the iterative nature of the NIPCM. So, it is a document that has been in use since 2012 and it is updated very regularly if there are any changes to policy or in response to an outbreak like COVID. So it's just to demonstrate that it is a live document and we do spend an inordinate amount of time making sure that the advice and guidance within it is correct.

Q Thank you. Now, what then happens in your witness statement is you're taken back to the Serratia incident and you're asked about IMTs and so on and so forth. Just looking at page 216, I don't think I need to take you through that material, but you list the kind of things

that an IMT should do, depending on the nature of the incident.

A Yes.

Q And that list, does it come from somewhere or is it simply from your experience?

A I had help with producing this list from Ms Imrie and her department, and this is what-- what would be expected of an IMT or a PAG.

Q Thank you. I just really want to pick up one or two very small points in relation to that. If we go on to page 218, we're still back at this Serratia outbreak which I know is before----

THE CHAIR: Sorry, entirely my fault. At 216/217, you set out the steps to be taken in an IMT. Now, I think I had perhaps wrongly assumed that that was a summary of the text in the manual but that's not right, is that----

A It may be.

THE CHAIR: Oh, it might be. Okay. Right. So it might be. The information comes from Ms Imrie?

A It does.

THE CHAIR: Okay.

MR CONNAL: Let me just go back then to 218. You were asked one or two questions which are in present purposes not particularly controversial but if you go to Question 7 there on page 218, you're asked about something described as reporting to the Policy Unit.

A That's right.

Q So, you then go on to give us an answer about that. Can you just summarise what this Policy Unit is about?

A So, the Policy Unit that you're referring to is the Chief Nursing Officer's Directorate Healthcare Associated Infection Policy Unit.

Q That's quite a mouthful.

A It is, and we report all incidents and outbreaks that have a red HIIAT or an amber HIIAT to them, or if they have a green, if they are put onto the reporting tool, then we will also inform the Policy Unit of any greens have required our support for any reason.

Q And you point out, I think on page 219, that there's guidance set out in a document that you produced as to the circumstances in which these reports are sent on, is that right?

A That's right, yes. So I think there was a DL in-- DL24 in 2024 which was around the reporting and communication requirements for outbreaks and incidents. The-- It talked about the responsibility of boards to report to ARHAI in line with the HIIAT, which is part of Chapter 3 of the NIPCM.

Q Yes. Is that essentially what you're setting out in the middle of page 219, the way the Scottish Government comes to give oversight?

A That's right.

Q Now, perhaps you can just help me with one point – it may not be entirely clear – on page 219 near the foot. You say you're aware from discussions with Assure staff that:

"... historically, the Scottish Government's supervision of incident and outbreak reporting could be dependent on the level of information and assurance required by the individual Cabinet Secretary for Health in post at that time."

Or indeed on the particular chief nursing officer.

A That's correct.

Q Well, first of all, has that changed?

A No. That's always been the case. So if-- if either the cabinet secretary or the CNO has had a particular interest in a type of infection or outbreak or a particular place or time, then they may well ask ARHAI to ask more questions of that board to clarify some issues.

Q Thank you. If we move on to page 220, because this is a point where you were asked a relatively short question and you thought it would be helpful to the Inquiry to give us a bit more information and perhaps a single sentence, so I'm keen to allow you to work through this. The question was, "What's the point of doing that?" Put in colloquial terms.

A Yes.

Q Sending reports to the CNOD HAI Policy Unit, and you've suggested there that it'd be helpful just to walk through the kind of genesis of this arrangement.

A Yes.

Q So if we could just go through that briefly, I'm not going to call up on the screen all of the documents you referred to, but if at any time you think the answer would be assisted by seeing a document, please just indicate and we'll do that.

A Thank you.

Q In many cases, I think you have probably lifted paragraphs that you think are helpful. Is that correct?

A Yes, we have.

Q So you start the tale on page 220 in 2000, where there's a joint working group which publishes a report on managing the risk of healthcare-associated infection.

A That's correct.

Q We see the bundle reference there: bundle 52, page 5. Now, in terms of matters, you've picked a number of key recommendations. Is that right?

A That's right, yes.

Q Including the adoption of national standards for IPC, decontamination of reusable medical devices. Is that two or one? One recommendation? Is that all one

recommendation, those first two sentences, first two lines?

A Yes.

Q One or two?

A One.

Q Thank you.

"Risk Management... Strengthening Accountability and Governance... Enforcement (sic) of surveillance and reporting."

Interesting that the-- Sorry. I said "enforcement". I misquoted; it's "enhancement."

A Enhancement. Yes.

Q And staff education training. So you think that's where we go to start.

A Yes.

Q And then the next stopping point is the report of the Watt Inquiry, is that right?

A It is, yes.

Q Following an outbreak of salmonella and that was in 2001, running into 2002, we see from page 221. Now, we see that the report appeared at that time with 47 recommendations. Can you just help me understand why of the 47 you've picked the two or three that you have?

A Well, one of-- the recommendation 30 talks about a classification system for infection outbreaks and episodes to be drawn up and that's what's resulted in the HIIAT green, amber, red status. So, the first time that we thought about classifying outbreaks and that the resultant-- how we use that now is to classify as green, amber and red.

Q Yes. You've also picked Recommendation 33 which seems to focus on the chief executive's role.

A And that was just really about the accountability for infections within an organisation at that time.

Q Then, if we go on to 222, there's another reference to the appointment of an issue manager, and then you say on page 222:

"... the profile of prevention and control of HAIs was transformed..."

That's quite a colourful word, if I can put it that way. Is that a word you think's justified in context?

A I think that probably it was-- I meant to say that there were some significant milestones that came out over the next few years, and there was a significant amount of work done around healthcare-associated infections and reporting.

Q Right. You list a series of these HAI Infection Control Standards, HAI Action Plan----

A Mm-hmm.

Q -- and educational initiative, organisational issues, and reporting coming out in 2009. So, you regard

these all as further steps on the way. Is that right?

A They are.

Q Then, we're back actually at the Watt report-- sorry, we're not. We're now going to the Vale of Leven Inquiry, which reported in 2014. Again, what you've done here is you've selected a number of recommendations that you think are of note. 46:

"... Infection Control Manager has direct responsibility for the infection prevention and control service..."

National guidance to be issued. Just pausing there on Recommendation 49 since it's a topic that's come up perhaps tangentially earlier in this Inquiry, I think some people have asked, "If you've got an infection control manager in charge of the infection control service, should that not be a clinician because it doesn't seem always to be somebody with clinical qualification?" Do you have any view on that?

A Yes. So, I'm not technically qualified and yet I lead a technical part of our organisation. I think, as long as you have an understanding of the processes in place and you have subject matter experts, as in ICNs and ICDs who can support you, I don't see why an infection control manager would need to be clinically qualified.

Q Thank you.

A Although, having said that, they do need to have a good understanding of the processes in place, and have a good working relationship with their clinical colleagues to ensure that they're properly informed.

Q Thank you. You set out one or two other recommendations from Vale of Leven, and then you say, in the middle of page 223 that, pulling all that together, these are the types of background factors that have informed what you described there as "national oversight" of HC-- sometimes HAI and sometimes HCAI incidents. They ensure that the Scottish Government is appropriately informed. Is that important?

A That's really important. It's important for a number of reasons, one of which is that, if a health board has a small number of incidents or outbreaks of a particular pathogen, they may not think that that is important or they may not understand that actually there may be a theme across a number of hospitals or health boards that are reporting the same infections.

I think that unless we have a holistic view of what's happening over a broader area, we aren't sure, and we can't mitigate risk in the infection prevention control arena, and there have been cases of single-- or just one or two cases in a health board, and one or two cases of

something in another health board, that has actually led to a recall of, say, perhaps a piece of medical equipment or something like that.

Q I see, thank you. Now, the next question you were asked is whether there's a provision for making more requests for more information, and you explain how that operates, and ARHAI notified the Policy Unit that-- can I just call it the Policy Unit for short, and then the Policy Unit review each incident and brief appropriate parties. So, that's the way it works. Is that right?

A That's the way it worked, yes.

Q Now, can I move, then, from the general to the specific, at least for a moment----

A Mm-hmm.

Q -- which is to ask you about the refurbishment of 2A and B in the----

A Yes.

Q If we just call it the "new hospital" for simplicity? I want to ask you a number of things about this, and perhaps to take you through a little more slowly than you might otherwise have expected some of the material that you've set out because quite a number of parties to this Inquiry, for fairly obvious reasons in many cases, are interested in what happened and why, and it has generated quite a few questions.

So, the order in which the questions have been asked don't necessarily lend themselves to us getting everything correct. So, if I get out of order, please just correct me. After some introductory material on page 224, you then go on to page 225 explaining that, in June, so this would be when-- just about when Assure was set up?

A Yes.

Q In fact, almost this-- it was June, wasn't it?

A It was June, yes.

Q June 2021:

"NHSGGC approached NHS Scotland Assure engineering team [or an individual within the Assure team] Senior Engineer (water to request support..."

The scope was outlined in the terms of reference document agreed between Assure and the NHSGGC project manager, and was limited to water only. Now, I'm going to come back to that point because a number of parties have asked us about that. Now, if you skip the next sentence, the summary, which you've lifted from the terms of reference, I think----

A Yes.

Q -- talks about attending fortnightly progress meetings when available, fortnightly technical meetings, weekly testing, site inspection visits and so on. Now, an outside reader might think that was expecting a commitment

by someone in Assure to do the things set out in the terms of reference. Would you agree?

A Yes.

Q Perhaps what doesn't emerge from the paper is the point you make a little in front of the bullet point, which is that the expectation was that NHSGGC would explicitly ask Assure if they were wanted at the meeting. Now, am I right in thinking, first of all, we don't find that come only if asked provision anywhere in the paperwork? Is that correct?

A I don't think so. I think that that was a verbal conversation between the engineer, his manager and the project manager at GGC at the time.

Q Now, I think we'll come on to an explanation that you give as to why it was like that but there is a significant difference, is there not, between being asked to help, a list of things to do set out and a list of things to do but only come if you're asked? They're quite different commitments. Would you agree?

A Yes.

Q What you say at the foot of page 225 in fact is that Assure didn't go to any of the meetings.

A No, they didn't go to any of those meetings.

Q Because you were never asked?

A That's correct, however that doesn't mean that they-- that they weren't involved.

Q I'm going to come perhaps on the-- I think you probably deal with it on the next page. Again, just looking at this from the perspective of an outside viewer looking in, it looks a little odd. The national agency has been asked for help, a series of duties set out, but you don't go to any of the meetings.

Now, on page 226, am I right in summarising what you tell us in answer to Question 14, that the reality was that a particular individual had moved from-- I don't know if there's any secret about it. It's AECOM----

A AECOM.

Q -- who were helping the Board----

A That's right. They were technical----

Q -- to Assure.

A That's correct.

Q Somebody in the Board wanted to make sure that if they needed him, they could get hold of him.

A Yes.

Q Is that a reasonable summary of your understanding of why this was set up?

A It is indeed, and I think also the GGC team had lost a member as well, and they wanted some continuity around support until AECOM's new technical

advisor was up and running.

Q Right. Now, no one went to the meetings that were envisaged by the terms of reference.

A No, but we did attend other meetings.

Q Can you explain-- This is perhaps a little puzzling to an outside reader. You've been asked to take on a particular term of reference----

A Mm-hmm.

Q -- turn up at these meetings. You're never asked to do that, so you don't go. How does it then come to be that you are at different meetings?

A So, we attended-- I think it was one of the water advisory groups, but Mr Beattie also attended site on numerous occasions. He provided observation reports and photographs, which are in one of the bundles.

Q I'll look at that just in a moment, if I may. I understand the factual narrative that you give me that Mr Beattie did, I think, what you describe here as a number of site walkarounds.

A That's right.

Q How did it come to be that he was doing these site walkarounds if it's not part of the terms of reference?

A So, it was-- it was what we were asked for.

Q Right.

A So, at the time-- and, you know, I wasn't in post at the time, however I think that GGC wanted some continuity. Mr Beattie had been the technical advisor from AECOM. They asked could we provide some provision. We agreed to that. They then, I think, only asked Mr Beattie to come round on the walkarounds, and to have a look at where they were up to and to give some comment on what he found on the walkarounds.

Q Right. So we can give some context, particularly to those in the room, I wonder if we could look at bundle 52, volume 2, page 73, please? That should come up on your screen. If we look towards the bottom of half of that page, this is Mr Beattie that you've referred to----

A Yes.

Q -- getting in touch, I think, with Mr Huddleston, who is the project manager or something of that kind----

A Yes, he was. Yes.

Q -- and listing, as you say, observations. Someone's put new flooring down, but no one's put blue covering on their feet, and so on and so forth. If we just go on to the next page just to make sure we see all of it. Then, further what you might describe detailed observations relating to the site operation in the context of the water systems. Is that fair?

A It is, and if we could refer back to the terms of reference, they do say at the bottom that we were to produce no documentation as NHS Assure. However, Mr Beattie felt it was important to let GGC know some of the things that he'd observed when he was walking around.

Q Okay, but let's just— particularly so his Lordship's notes will follow that, if we go to page 72. Now, is this the terms of reference document?

A It is.

Q Yes, I see at the very foot of that page:

"HFS [never mind the nomenclature for the moment] will not produce any documentation during the support, other than record photographs and confirmation of items raised during site visit reviews."

Might be slightly ambiguous as to whether site visit reviews should be documented but, in any event, that's what Mr Beattie did?

A He did.

Q You've identified several more, and I think I'm right in saying they were along similar lines where he's produced a list of things he saw on site which he felt he should record.

A Yes, and he did that on-- he had a site visit on 22 July, 5 August and 8 October.

Q Right. Now, we have these in in bundle 52, my Lord, at 73, 82 and 93.

THE CHAIR: Sorry, you've lost me there. We're still on the terms of reference.

MR CONNAL: No, we're now moving from the terms of reference to where one finds the reports that – let me just call them "reports" for the moment – Mr Beattie prepared, an example of which was at bundle 52, volume 2, page 73. Similar examples are at 82 and 93.

THE CHAIR: Thank you.

MR CONNAL: My colleagues have helpfully brought up page 92, just while we're here. Again, it's a detailed list of----

A It is.

Q -- items and the other one will be the same. So the point you then go on to make, if we go back to your witness statement, is that although Mr Beattie is doing these walkarounds and reporting on them, he isn't signing off. Is that right?

A That's correct.

Q So he's not going to the meetings, but he's doing some walkarounds because that's what you've been asked.

A Mm-hmm.

Q He's doing detailed reports, but he's not signing off or handing over. Correct?

A No, he's not. That would be the technical adviser who would be doing

that.

Q The GGC employed technical adviser?

A Yes. That's right.

Q So that was the limit, as it were, of what Assure was doing at that point?

A No, it wasn't. So, slightly later----

Q Well, that's what I was just going to come to.

A Oh, right, yes. No, at that point it was, yes.

Q Yes. Because on page 226, you say, "These steps continue with limited input from Assure until February '22," and then something happened in February '22 where there was a further development. Is that right?

A It is. But I could also give the Inquiry an update on what happened over the December period as well, if that would be okay.

Q Yes, well, please, add to our understanding. That would be very helpful.

A So, at the beginning of December, I think round about the 6th, Ian Storer----

Q This is December 2021?

A December 2021.

Q Thank you.

A Ian Storer, who was-- who is our AD of engineering, and Annette Rankin attended a water meeting. So a meeting about the water issues on 2A/2B. They were asked to attend as critical friends. They----

Q Now, hang on. Pause there. Pause there. I'm not sure we've heard the phrase "critical friends."

A That's Ian's colloquialism around describing our function.

Q Right.

THE CHAIR: It's not an unknown expression.

MR CONNAL: No. That's his understanding of what he was----

A Yes.

Q They weren't there as official participants; they were there as sort of----

A Advisory capacity.

Q -- attendees to help.

A Yes.

Q Right. So I apologise for interrupting your narrative. This is December?

A This----

THE CHAIR: Well, could I interrupt the narrative----

A Yes.

THE CHAIR: -- by asking you maybe to go a little bit slower because this is-- I mean, we don't have the help of the statement.

A No. I apologise. So----

THE CHAIR: So attended, what I've noted as, a "water meeting."

A That's right. Yes, on 6 December. So-- And then following on from that, on 8 December, we received an email from Euan Smith around proposed actions to address the water issues that were discussed in that meeting. And Euan was-- I think that he was a deputy director of Estates from GGC. He sent that email to----

THE CHAIR: Sorry, I missed that. Mr Smith was----

A I think he was an associate director, deputy director of Estates.

THE CHAIR: So it's GGC?

A At GGC, yes.

THE CHAIR: Right.

A So then there was an email trail around-- on the 8th around-- Ian sent on some information to myself, Laura and Annette re some of the issues, and then the activity timeline email came through, which was-- which was what was proposed by Euan in his email of earlier that day. And then there was an email trail from Ian – Mr Storer – including Ms Imrie and Ms Rankin and they produced some response of that. Then we can go to her evidence in bundle 14, volume 3, but I don't know what page. I do apologise.

MR CONNAL: Well, you just tell us what it is and we'll look.

A Okay. It was an email from Annette Rankin to Tom Steele and Sandra Devine with some questions that we felt it would be beneficial for them to be able to answer, in order to address some of the issues. We then sent a chaser email on 15 December as well and, on 16 December, Mr Steele replied to Annette saying that he would meet with me and my team to discuss. I-- I don't-- I've had a look in the diary and I don't have any recollection and I can't find any evidence of that, although we may well have spoken on the phone, but I don't recall that.

Q Now, I think what you've been telling us, if I'm picking this up correctly, is that there were some email exchanges in December, which the Inquiry probably doesn't have.

A I don't think you do. We'd be happy to supply them for you.

THE CHAIR: Could you do that?

A Yes, yes, of course.

MR CONNAL: That would be helpful. Your solicitors will know where to send them and we'll make sure that they're available to all the participants in the usual way, and then you link that to some items in bundle 14----

A That's right.

Q -- which we can no doubt find in due course, in any event, led to a suggestion of a meeting and you don't now recollect the details of that?

A No. So then on 21 January----

Q 2022 now?

A -- 2022, Annette – Ms Rankin – also sent another email to Mr Steele with the offer of the Short Life Working Group and a walkaround to support GGC in the reopening of 2A/2B.

Q We do have material on that topic.

A We-- You do, yes.

Q But I'm going to press the pause button at least temporarily because we come back to that in your witness statement later----

A Okay.

Q -- if I may. Just so we don't get out of sync with the sequence in your witness statement, in your witness statement, the first event that you identify after the walkarounds continuing on a limited basis is a communication from the chief nursing officer. Is that right?

A That's correct yes.

Q In February 2022.

A Mm-hmm.

Q So if we go to page 227, I just wanted to ask about this. Can we see bundle 52, volume 5, please, page 84? Now, if we go to the second half of that page, is this the email that you're referring to?

A It is.

Q So this is going from Professor McMahon to various people, including yourself.

A Yes.

THE CHAIR: Right, just a matter of small detail, so in the answer – just to make sure I'm keeping up – below 15 on page 227, there's a reference to an email sent by the CMO. Should that be CNO?

A Yes, it should be.

THE CHAIR: Right. Okay, thank you.

MR CONNAL: And the email you're referring to there, I take it, is the one we're looking at, at the moment?

A It is.

Q Which, as I said, goes from Professor McMahon to various people, including yourself and Mary Morgan, who's the chief executive at the time----

A That's correct.

Q -- and essentially is suggesting a meeting to discuss where next. Is that fair?

A Yes, that was a meeting of the AARG group, but myself and colleagues met incredibly regularly with Glasgow over the next week or so.

Q Now, we'll probably come back to this, but also in the answer to Question 15, you talk about the "supported pathway."

A Mm-hmm.

Q Now, what do you mean by that?

A So, because we were in the middle of the commissioning phase of

this refurbishment and because there was a time constraint around the necessity to reopen the ward, we were asked what could we do to help support GGC and having some assurance that their water was safe within the unit. And so we worked on a pathway provision to mitigate the risks, and the pathway was based on the principles of a KSAR.

So it looked at risk assessment, water sampling, water management, so flushing and dosing, and how much involvement the Water Strategy Group had had, so some governance issues as well. And we came up with a pathway document which was an Excel spreadsheet that GGC could drop their evidence into and we could see that they had evidence around supported.

THE CHAIR: Right. At the risk of just saying back to you what you've just said to me, I mean, Assure was producing, as it were, a framework?

A Yes.

THE CHAIR: Presumably with questions and it was for GCC to essentially report what had been done?

A Yes.

THE CHAIR: All right. Again, so I'm keeping up, it's what had been done specific to Wards 2A and 2B?

A Yes, and in relation to water only.

THE CHAIR: In relation to water, and including perhaps general water governance questions?

A Yes.

THE CHAIR: Right. Okay, thank you.

MR CONNAL: Let me just ask you, because you've been asked that in your witness statement at page 227, the issues around Ward 2A in particular had been – well, let me just call them – controversial in a variety of ways. Obviously, issues had arisen. Lots of things were having to be done.

A Mm-hmm.

Q A fair number of these were focused on ventilation provision. A lot of the work that was being done was focusing on ventilation provision. Now, from an outsider's perspective, looking in on your organisation, it seems a little odd, perhaps, that you're not all over the question of ventilation as well as helping out on water. Is there any explanation for that?

A We-- we were never asked to support around ventilation. So at the time that the refurbishment was happening, that was in the majority pre-NHS Assure. We were in the process of developing the KSAR workbooks, etc. However, there was no mandate for GGC to engage our services or to-- to utilise our staff collaboratively.

Q Now, when you say, "There

was no mandate," am I right in understanding you mean that no one had asked you to do it?

A That's correct, yes.

Q Or instructed you to do it----

A Yes.

Q -- depending on where the communication comes from?

A Mm-hmm.

Q I think you're basically being asked in the witness statement, "Well, you know, is that not a bit odd?" Should you not have been saying to someone up the line, "Surely we should be involved in ventilation as much as in water?"

A And I think that probably, had we had time, we may well have done that. However, at that point in time, when the refurbishment was happening, that was prior to NHS Assure. So the usual way of asking for support from HFS was to do that, was to ask for support. There wasn't a KSAR process in place at that point in time and, therefore, this refurbishment also.

There are two criteria that you have to meet for a KSAR to be enacted with an organisation or engaged with an organisation, and that is that the refurbishment or new build is above the delegated authority level for that board or it has been-- had an outline business case, full business case, go through the CIG meeting, and this didn't meet either of those thresholds, but it was prior to the development and start of Assure.

THE CHAIR: Again, just from my notes, you said two criteria.

A Yes.

THE CHAIR: I seem to have only managed to note one criterion. The first criteria is that the project, whether it was refurbishment or new build, had gone through a process of either outline business case or full business case, having been considered by the----

A Yes.

THE CHAIR: -- CIG, the Capital Investment Group.

A That's right.

THE CHAIR: Right, so is that one criterion or----

A No, there's two. So, the second criteria is that the project does not-- for us to be engaged, it has to exceed their delegated authority level.

THE CHAIR: Right, yes. (After a pause) So, at least in terms of the criteria laid down for KSAR, even something like the rebuilding of the ventilation system of Ward 2A wouldn't qualify because it would never be outwith the Board's borrowing power.

A That's right, but that's not to say that they couldn't request support from us in a different way, so we do still have-- the majority of our work comes outwith the healthcare build KSAR

process. So, we do still have a commissioning process through which a board is able to ask for support from a subject matter expert.

THE CHAIR: I perhaps should know the answer to this question. Assure was established in June 2021. How far had the refurbishment, a project, progressed by the middle of 2021?

A I think that it was quite far along.

THE CHAIR: Mm-hmm. I mean, things had been built.

A Oh, yes, things had been built. There were-- You know, the wards were there, infrastructure was being put in, so it wasn't like it was just at the planning stage or anything. It was actually at the construction and probably commissioning stage.

THE CHAIR: Right.

MR CONNAL: You mentioned a moment or two ago there was the challenge of keeping some kind of chronological order, the provision of a pathway and what that was, the spreadsheet that you explained to us, and is this what you're discussing on page 228 of your witness statement in answer to Question 18?

A Yes.

Q I'm not sure-- The document you're referring to there, is that the pathway or is that the standard KSAR material?

A I think it's the standard KSAR material but it was just to demonstrate that it would be following the KSAR principles.

Q In terms of what was actually done, you identify in paragraph 19, on the same page, the individuals, Mr Storer, Ms Rankin, Michael Weinbren----

A Yes, Dr Weinbren, mm-hmm.

Q -- who's a consultant microbiologist, and also Dr Lee, who we've----

A Yes.

Q -- come across already. You asked them to provide input and expertise.

A We did.

Q So, you're producing a pathway. Are you, as it were, ensuring compliance with the pathway or are you simply producing the pathway to show what needs to be done?

A We're producing the pathway to show what needs to be done. The responsibilities still lay with NHSGGC, and it was up to them to ensure that the mitigation actions were taken forward.

Q Thank you. Now, you're then asked a number of other questions which are, I think, designed to identify where there are links between the processes that you're responsible for and other processes which arise under the

healthcare system. You're asked, for instance, in Question 20 about validation but, before I go to the detail of that, can I just ask this? In the course of evidence from Dr Chaput not that long ago, the Inquiry heard about a particular difficulty that's been encountered in the water system of 2A. In particular, there was what I'll describe as gross microbial contamination discovered notwithstanding flushing and other arrangements during the period that it was being redone. Were you aware of that in the sense of Assure?

A I think that we were aware of that during the meetings in December, which is why Mr Storer and Ms Rankin then became involved, and the emails from Ms Rankin thereafter, to Mr Steele with an offer of support and a walkaround.

THE CHAIR: Could I just run that back? Now, Mr Connal, you used the expression "gross microbial contamination." Is that a quotation from the Water Research journal article?

MR CONNAL: No.

THE CHAIR: Right. What's the----

MR CONNAL: The source is simply my summary of the finding that there was significant substantial microbial contamination discovered when steps were being taken to consider moving forward.

THE CHAIR: Right, so the Chaput article may or may not use the word "gross."

MR CONNAL: Yes.

THE CHAIR: It probably does use the expression "microbial proliferation," and you were aware, Ms Critchley, of microbial proliferation having been identified in the course of, or possibly commissioning of, the refurbishment works as at the date of the meeting in December 2021 that you mentioned to us. Sorry, just----

A That's my understanding.

THE CHAIR: I'm keen to keep up. Right.

MR CONNAL: It may be that something along these lines is mentioned in the emails that we don't have but which Ms Critchley will facilitate our being supplied with. (To the witness) Now, I can probably move reasonably quickly past the next few questions. You're asked about, "Well, what connection is there between validation and NHS Assure?" and what you say in answer to Question 20 is, "Well, there's a number of circumstances which we might be involved, but there's an AE provision," which I'll just take from you now. As of November '23, Assure can provide the services as authorised engineer to healthcare operations in Scotland. Is that right?

A Yes, we can, although not all boards choose to utilise us. Some of them do have experts commissioned from elsewhere.

Q Yes, so it's an option that you make available, it's not a requirement?

A No, it's not.

Q Thank you, and then you point out, and I think you've probably already covered this in your evidence, that you may be asked for help, in which case you'll apply the kind of KSAR principles, and then you're asked about L8 assessments on page 229, and you say, "Well, these are things under the responsibility of the Board."

A That's correct.

Q But, if you were involved, either because you were helping with a KSAR-type process or through an authorised engineer audit, then that's something you'd be checking.

A That's right, slightly different roles, so the AE may conduct the audit, and the KSAR would ask for evidence that an audit has been conducted.

Q If one's looking to see whether an L8 Legionella water assessment has been done, that could crop up in either of these.

A Yes.

Q Is that correct?

A Yes.

Q Now, you're asked about who you were communicating with, and you probably already indicated that in the context, at least, of Professor Steele, but I see also at the foot of page 229, Professor Wallace. Is that right?

A That's correct.

Q You asked your colleagues who they were communicating with and they added Sandra Devine, Gerry Cox – who seems to be the Estates – and Mr Huddleston that we came across earlier.

A That's right.

Q Did you understand Mr Huddleston was the project manager for the refurbishment project?

A That's my understanding, yes.

Q Then, you're asked on page 230, and this may be coming back to the sign-off point, "Well, what about risk assessments and so on? What were done?" and you say, "Well, it wasn't really our input." Is that right?

A Yes. Although we looked at risk assessments in relation to water, we didn't for anything else.

Q You say, I think, in answer to Question 23, you've checked to see if anyone has any recollection of going through the sort of final testing----

A Yes.

Q -- and no one could find that.

A No. One of the briefing-- We produced a briefing statement on 24 February that said what input we'd had to

Wards 2A and 2B and what actions would need to be taken before the ward could be opened, but we didn't have sight of those final testing or handover materials, and I do have a couple of emails from-- I think it was Angela Wallace back to Laura Imrie on the-- I think it was 28 February. Laura took over from me around the ARG work because I was in America for my son's wedding.

Q Can we just have a date for that?

A I left on the 27th and the meeting-- the ARG meeting was on 28 February.

Q 2022.

A 2022.

Q Thank you. Now, one of the topics that has generated a degree of controversy----

THE CHAIR: Again, can I just confirm that? So, what we have is that your answer to Question 23 on 230 is Assure commenced the pathway work. Now, is that between 20 and 22 February? Now, is that the issue of the framework document?

A It is, yes.

THE CHAIR: Right. So, on 20, 22 February, Assure provides GGC with essentially an indication of what they should do----

A Yes.

THE CHAIR: -- and then GGC engaged with that, they----

A They absolutely did, yes.

THE CHAIR: -- respond----

A They actually gave us the first tranche of information on the 17th before we'd finalised the question set on the pathway.

THE CHAIR: Right, so the envisaged process of, "Here's what you should do," "We've done it," proceeded through the latter part of February until the opening of the----

A Our involvement ended round about 28 February----

THE CHAIR: Round about----

A -- when the-- round about when the ARG took the decision that they were assured that the ward water supply was safe.

THE CHAIR: My recollection is the ward was announced as opened in the latter part of March.

A I believe so, yes.

THE CHAIR: Yes, right. I'm thinking about maybe about 21 March. Right, sorry Mr Connal.

MR CONNAL: Can I just make sure I've not missed it, Ms Critchley? When you were giving the start of that answer, you said, "I think there were emails involving Laura Imrie." Are these ones you've identified as ones that the Inquiry has or not?

A I don't think that you do, so we

would be happy to make those available to you as well.

Q Maybe you could add those email exchanges and then we'll make the suitable arrangements for them to be published. What are they about? Do you know?

A They're just about-- So, the way that we communicated and collaborated was we had a large number of Teams calls but we also had a Teams channel in which we put the document and GGC put their evidence in, and we noted that on the 4th, after we'd provided our briefing statement that there was a download of more information, or an upload of more information to the Teams channel.

Laura picked that up as I was away, to say, "We now don't have any more involvement. What would you like us-- Is there any particular reason that you've put more information in?" and I think Angela Wallace responded to Laura to say, "No. It was just for the sake of ensuring that we had everything in one place for information and completeness. You don't need to do anything."

Q Thank you very much. I think it would be useful if we added these emails to our ever-growing collection.

A Yes.

Q Now, let me bring you back to a statement you made a little earlier about a possible short life working group.

A That's right.

Q Because depending on one's perspective-- it has, for instance, been suggested that Assure offered to come and have a look at everything and GGC said, "No. Go away. We don't want that." I'd like you to try and move from my personal colloquial summary of things that parties have suggested to what your understanding was of what actually happened. So, if we go to page 230, we see that in the middle of the page there, that your – that's you, being Assure – initial suggested way forward was to establish what you described as a short life working group:

"To explore and discuss relevant details, including testing... and undertake a walk round of the refurbished wards."

Well, first of all, why did you suggest that?

A Because we found that that's usually a good way to do a piece of work in a limited amount of time and it came out of the water meeting on 6 December. So, we had some email conversations between 7 December and 21 December. On the 21 December, Ms Rankin sent an email to Professor Steele about meeting as a short life working group and walking around the unit to support the opening in respect of water.

On the 28th, we had an email from

Professor Steele to Ms Rankin in which he said that there wasn't enough time for us to pull together a short life working group.

We then-- Annette then sent out an email to some of our microbiologists around the water results and there were conversations backwards and forwards until we then were asked to link into the Advice and Assurance Review Group, the AARG, on 17 February when I became involved.

Q I think we picked this up later in your witness statement, so we might just go there because one of the questions which has now arisen is what the proper understanding should be of Assure's role in the reopening of the ward, given the constraints that you've explained to us. So, on the water side, you've got initial suggestion of meetings not required, then some walk arounds, no signing off of anything but then there's the pathway process on which you're assisting. Is that right? And then ventilation----

A Not in any technical way whatsoever. I facilitate it.

Q So you're providing the pathway, but you're not inputting any technical input into that?

A No.

Q And nothing on the ventilation side?

A No.

Q I'll try and get back into the sequence if I can. So if somebody said, "Well, are Assure signing off on this new ward," the answer would be what?

A No.

Q No.

THE CHAIR: I suppose you didn't really have any structure within which to operate. I mean, it----

A We didn't. We didn't.

MR CONNAL: Yes. You picked this up on page 232 of your witness statement, about halfway down the page. You actually say this:

"While NHSScotland Assure was able to support NHSGGC in the reopening of Wards 2A and 2B in relation to water safety, by developing the pathway, we could not offer assurance in respect of the wider ward environment due to the tight time frames and NHSScotland Assure's lack of detailed involvement in the refurbishment work..."

The work was well underway as his Lordship has taken from you by the time----

A It was.

Q -- you were created, as it were.

A Yes.

Q And then you didn't get involved in ventilation at all, and then you're asked, I suppose, slightly repetitively, "Well, did you offer to go and

inspect it?" and you said, "Well, what we offered was the short term----"

A Short life working group.

Q Working group.

A But Mr Beattie did go and do some walkarounds that resulted in the emails that we discussed earlier.

Q Yes. So, if we go to 233, where you've been asked about this offer, the next question, 27, "Well what form did the offer take?" and the answer is, "Well, initially a verbal offer." Is that right?

A Yes, initially a verbal offer and then that was followed up by the email from Ms Rankin on 21 December.

Q Now, could that be the-- let me just check the document. In 28 you reference an email 21 January. Is that a misprint? Should we get the email up? Bundle 14, page 350.

A No, it was January. Sorry.

Q It was January?

A Not December. Sorry, that's-- that's my mistake.

Q Okay. So then there was an email of 21 January from Annette Rankin to Tom Steele and Sandra Devine and then what you've done there I assume is to lift a quotation from the content of that email. Is that right?

A Yes.

Q And this is the short life working group facilitated by ARHAI and HFS:

"...which includes microbiology, clinical and scientific input to work with NHSGGC and review the work undertaken, results being obtained, risk mitigations in place in an attempt to support NHSGGCs repatriation of children back to Wards 2A/B."

So that appears to offer quite wide-ranging support in basically checking. Is that right?

A Yes.

Q And was that the intention?

A Yes.

Q And the response was it would take too long?

A Yes.

Q Would it have taken a long time?

A No. As you-- as you can see from the timeline when we were supporting the water, we-- we were asked to do that on the 17th. We'd have the download of the first information by the 17th, we had the pathway formulated by the 22nd, and we had reviewed the information and produced a briefing by the 24th.

Q So the short life working group might not have taken a great deal of time to put together?

A No. We would have made that a priority.

THE CHAIR: Is there a distinction between putting the group together and it

completing what it can do?

MR CONNAL: That's the appropriate follow-up question, my Lord. You gave me an answer a moment or two ago about speed in dealing with another issue like the pathway and you've just said that you would have given the short life working group priority. In terms of what you had anticipated would be required to, as it were, get boots on the ground, to use that expression, would it have taken long to organise?

A No. No, the ask would have gone out for two different areas within Assure to the associate directors, and they would have been able to pull together a short life working group with the relevant skills in a relatively short period of time. A day or two.

Q A day or two? And thereafter they could have been at the hospital?

A Yes.

Q Can I just ask you to help me with one answer you've given on page 234, where you're asked the question, "Well, were you concerned that your offer had been declined?" and what you say there is that staff-- and you mentioned Mr Storrar, Ms Rankin, is it Dr Weinbren?

A That's right.

Q Were concerned that they might be asked to comment on overall ward safety and wouldn't be able to do so because they'd not had all the materials to do that.

A Yes, that's right.

Q That's something that seemed to bother them. Am I right in picking that up?

A I think that they didn't want to make uninformed comments around other areas of the refurb because they'd only been involved in the water refurbishment. So, therefore, if they hadn't seen any information and they hadn't reviewed any reports then they would not be able to comment on the overall ward.

Q The reason I kind of pause a little bit on that is that you mentioned earlier in your meetings with the AARG----

A Yes.

Q -- the group that was looking at compliance with recommendations from various sources on the part of GGC. Now, it may not be entirely clear, but do you ever recollect being asked by the AARG if Assure were able to provide assurances about the safety of the new ward being opened?

A I don't recall being asked to do anything other than the water.

Q So if the AARG had the impression that Assure were on top of all aspects of the refurbishment, that would be incorrect?

A It would and they would be

aware of that through the briefing statement that we issued on 24 February that we had only looked at water and nothing else.

Q Right. Let's make sure we know what you're referring to. The briefing note on 24 February? Have we looked at that already?

A No, I don't think that we have. It is in the bundles.

Q It is in the bundles?

A It is in the bundles.

Q So this is a briefing note from Assure indicating what you, in effect, what you have----

A Yes.

Q What the limits of what you have done are?

A Yes. And giving-- I can't find it. I thought I had it in my pack. And giving assurance that if the-- if the pathway was completed and the information was available, then the water-- we would support the reopening of the ward in respect to the water, nothing else.

Q Right. Thank you.

THE CHAIR: Sorry, do we have a reference to that document?

MR CONNAL: Let me just check. Bundle 21, volume 2, page 15. Okay, so that's the right one.

A Yes, that's it.

THE CHAIR: Right. Thank you.

MR CONNAL: So this is the document that we were just trying to find.

A Yes.

Q I've probably jumped a little ahead of its reference. It's referenced, my Lord, at the end of Answer 32 on page 235 of this witness's statement. Can we just look at it and we'll just make sure we understand what it says? Well, first of all, it says it's a briefing statement regarding water supply.

A That's right.

Q So it says nothing at all about ventilation?

A No, it doesn't.

Q And then we'll just go on to the next page. Then you've set out there, you're going to use KSAR projects. You set out the timeframes. "Information was provided to us." So, at the foot of the first page:

"...several recommendations for action prior to opening wards 2A and B, they are listed below."

Go on to the next page. "We have discussed these..." That's today. That's the 24th. "All will be completed." So, what you then say in this document is:

"... NHSS Assure based on the... information presented to us, are able to support the reopening of Wards 2A and B at [the hospital], subject to... confirmation of the action plan and commitment to address the issues identified."

So you've laid out what you think

needs to be done.

A Yes.

Q You've been told it's either been done or being done and that's the basis on which you say, "Fine"?

A Yes.

Q That's the limit of your organisation's involvement in 2A?

A It is.

Q Thank you. Can we just have a look, please – I've got some other questions I've been asked to put to you at this point – at bundle 27, volume 10, at page 46? So this is simply the same document appearing in a different location. So we've already got that as the context.

Now, I've been asked to ask you this question. If you can or can't answer, please just let us know one way or the other. Assuming that that document is correctly interpreted as, as it were, "giving the go ahead" in that communication, what action would you expect to be taken in the Infection Prevention and Control team if cases of environmental gram-negative bacteraemia occur?

A Are you talking after repatriation of the----

Q Yes.

A We would expect the NIPCM guidance to be followed, and there should be a HIIAT after which, if applicable, they should be reported on the outbreak reporting tool as per Chapter 3.

Q Thank you, and the other question I've been asked to put is, if the IPCT decided, after root cause analysis, that all cases were due to gut translocation----

THE CHAIR: Let's take the question slowly.

MR CONNAL: Yes.

THE CHAIR: If the Inquiry is----

MR CONNAL: Yes. If the Infection Prevention and Control team decided, with root cause analysis, that all the cases were due to gut translocation – it's not a conclusion reached, for instance, by the CNR – does that change what you would expect to be done if there was a case of environmental gram-negative bacteraemia?

A I think that I probably need to refer back to Ms Imrie's evidence around not every trigger results in a HIIAT or an ORT. So I think that that would depend upon the set of circumstances, and I think that my IPC colleagues would be more able to answer that fully for you.

Q Thank you. Given the discussion we've had, the answers to the next questions may, in a sense, be obvious but I've been asked to ask you these. Were you aware that, when 2A and 2B were reopening, GGC decided not to do air sampling to give any assurance on air quality in the ward?

A No, I was not aware of that.

Q So, whether they should or shouldn't, was that approved by anyone on your team?

A No.

Q If it's not done now, do you have any comment to make on it?

A I think that they should be in line with the DLs and the CELs around that, and with the guidance. So, for ventilation, that would be-- I think it's 04-01 or 03-01. I can't remember which one----

Q 03-01 probably.

A 03-01. So-- And they should-- they should follow the guidance in that or, if they're not sure, then they could contact NHS Assure and we would be able to support them with that.

Q Thank you. Now, let me move on then to ask you some more general questions about Assure. So, if we take the document down. Thank you. If we go back to page 235 of the witness statement, and you're asked a fairly general question:

"Do you believe that it should be mandatory for health boards to get new construction or refurbishment approved by NHS Scotland Assure?"

You start your answer by saying:

"[It's] mandatory for Health Boards to engage with NHS Scotland Assure assessment processes [where the project is] above delegated authority financial limit."

Now, "engage" is one of these words that can have different meanings depending on how it's deployed. Is requiring engagement enough, in your view?

A I think it is, because I think that the boards understand that that actually means that they need to participate in, follow the assessment and the assurance processes, which, you know, we have an NDAP process which has been mandated since 2010. We have the KSAR processes, which have been mandated since 2023. So I think that the boards who have been through this process have engaged incredibly well with us.

Q One of the topics that's propped up from time to time in the context of regulation – and let's put it under the same head for the moment, I know you're not a regulator but, nevertheless, you're involved in reviewing and supporting a project – is a situation where a party is thought to be-- we used to use the phrase "paying lip service," in other words, doing what the rules say you have to do even though you don't think you need to do them in the first place. Now, do your processes address what might happen if a party was behaving in that way?

A Yes. So, the-- the processes

that we have within the KSAR and the NDAP require us to meet very regularly with the boards on a number of topics, and it then requires them to produce information to show that they have understood what we're asking, and that they are looking to be compliant with legislation and guidance. I think that it is important that we do that in a collaborative way, so we do. We meet face-to-face, we have information exchanges, and I think that, to date, those boards that have been involved in the KSAR and the NDAP process since NHS Assure's inception have been incredibly supportive and supported of the processes that we now have in place.

We have much more of a-- of a governance framework than was ever in place before, and I think that some of the boards that are going through a KSAR process and have had more than one KSAR process – so there's a number of programmes that have gone through more than one KSAR – have really welcomed the process and understand that, actually, it gives them and their board assurance that they are conducting themselves in the right way, and that they are compliant with legislation around their new healthcare build.

Q The fault may be mine, but I'm not sure you've quite picked up my question----

A Sorry.

Q -- in the sense that, if I understood the answer you just gave me, you've said, "Well, the people that have been through all of this have been very supportive, they feel very supported, they've been very positive, some of them have now done it more than once" and so on. So you've been in receipt of positive attitudes. I think the question that I was trying to get at – and it may not have been very well – was, well, what happens if you get a participant who is, as it were, ticking the boxes, paying lip service? "I have to do that. All right, I'll do that. Don't think I need to do that," is the message you're getting but they're nevertheless ticking the boxes. I'm just wondering whether your processes cope with that situation?

A They would. So, we would then have an escalation process if we felt that a board was not engaging appropriately or delivering the right sort of information that we've requested, and there is also the Capital Investment Group. So if a board has an unsupported status for an NDAP or a KSAR, then that will ensure that the board is not able to move on to the next stage within their build, and also, very helpfully, we had a DL in 2023 that said unless the handover KSAR and commissioning were-- received a "supported" status, then the

building couldn't be open for occupation by patients or staff.

Q Thank you. Am I right, just while you're on that point, that you have provided, in an appendix to your statement, a list of all the Scottish Government letters of that kind----

A Yes.

Q -- in case the Inquiry needs to access any particular one?

A Mm-hmm.

Q Now, you were then asked, "Well, what about 2A and 2B? Did that fit this?" and I think you point out, well, first of all, apart from the obvious part, that it was only dealing with water and not with ventilation.

A Yes.

Q It was done over an accelerated period of time----

A It was.

Q -- and therefore it wasn't a full KSAR process but similar.

A Yes. Followed the principles.

Q Now, I think you're probably in the search, as we'll come to later, for understanding the extent to which lessons have been learned and things have moved on. You were asked about a project in Aberdeen, page 236. So how did that work? How did it go? What did you take from that?

A I've got some notes on this.

Q Paragraph 36 of your witness statement.

A Could you pull up paragraph 56, please?

Q 36.

A 36. Oh, sorry, I thought you said 56. Right. Yes, so this is-- this was around the hospital projects in Aberdeen, where when we performed a construction stage KSAR on each of the buildings, that there were observations in relation how to-- the Board had recorded derogations.

Q Derogations from----

A From the guidance.

Q From guidance. Any particular type of guidance?

A I don't know the detail. And how they'd recorded that and what had they done to consider and mitigate the risks of not-- not complying with guidance, and what we did with them was that we developed an action plan to address the recommendations, and they've pulled together a dedicated workstream to look at derogations, but we are also doing a large piece of work around derogations.

So, we are looking at a once for NHS Scotland approach towards derogations. As part of that process, we have drafted a document which has gone out for consultation, and we are looking to publish that in winter this year. So it will look at how the risks and mitigations are considered, and then how we can capture

approvals of processes that have been put in place. We were working with NHS England around that as well, and they are interested in the document that we are about to publish.

Q This Inquiry has heard quite a lot of evidence about derogations. Have you looked at that?

A Yes.

Q Thank you. So, the idea is that there should be guidance on these different aspects of dealing with derogations----

A That's right.

Q -- in part as a learning from the Aberdeen project?

A Yes, and we also have the potential for derogations within IPC as well, and we have a process in the DL 2024 which states that any decision to derogate should be considered and approved in line with the local health board governance and must frequently be reviewed within those structures. So if you're derogating from reporting measures then that should be noted.

Q Thank you. Well, I was about to ask you another question, but I'm conscious of the time, my Lord. It might be as well to take the break now as at any other time, unless my Lord has a follow-up question now.

THE CHAIR: We'll do that. Can I just pick up on the last answer? (To the witness) In your answer to Question 36, you draw our attention to the current work that Assure is doing on derogations. Now, I simply did not hear the last couple of sentences you used. You were talking about derogation from requirement to report, if I heard you correctly. Now, I didn't recognise what we were talking about.

A So that was IPC reporting. So, if a board chooses to derogate from the NIPCM Chapter 3 reporting mechanisms, then they must have that approved in line with the local health board governance and that should be reviewed frequently within those structures because of course reporting is not mandated.

THE CHAIR: Right. But the work on derogation includes considerations of how one should make decisions on derogation and record derogations in relation to the Scottish Health Technical Memorandum?

A That's right.

THE CHAIR: Right.

A So that's a technical derogation process that we're in the middle of producing.

THE CHAIR: Right. Now, Mr Connal asked you whether you've looked at what the Inquiry has heard about derogation and I think your answer to that was, "No."

A No, it was, "Yes."

THE CHAIR: Yes. Sorry, it was "yes"?

A Yes.

THE CHAIR: And do I take it that you have read the Inquiry's Interim Report?

A Yes.

THE CHAIR: Right. We'll take a break now. I think if it occurs to you there is anything in the Inquiry's Interim Report that you would wish to take issue with or disagree with or make a comment about, I would welcome hearing that at some stage in your evidence.

A Okay.

THE CHAIR: But we'll now take a coffee break, and could I ask you to be back for five to twelve?

THE WITNESS: Yes.

THE CHAIR: Thank you.

(Short break)

MR CONNAL: Thank you, my Lord. (To the witness) Just on a point of administration, am I right in understanding that, from time to time, you are consulting personal notes that you made on the topics----

A Yes.

Q -- that are covered in the witness statement, is that right?

A Yes.

Q These are just notes that you made yourself----

A Yes.

Q -- on some of the issues?

A They are.

Q Thank you. So, if I just repeat the informal indication I gave to you earlier that, if you're going to look at any other document other than your personal notes, can you please alert us so that we can identify it and then, if need be, show it to the room?

A Yes, of course.

Q Thank you very much. Now, I may go backwards in a minute but, just at the moment, I just want to pick up on the very last answer I think you gave before lunch when you were talking about derogations----

A Yeah.

Q -- and then you were talking about possible derogations from reporting mechanisms.

A Yeah.

Q Now, we're on page 237 of your witness statement, second paragraph there. But then you say right at the end of that paragraph, which I think is the last thing you said, that reporting in this way is "not mandated". I love that phrase that seems to be the in one now. It seems to be used presumably as a kind of more comfortable phrase than "compulsory", which might be another way of putting it. Is that right?

A It is.

Q It might seem a slightly odd situation to have non-compulsory reporting, given the importance that you've indicated attaches to reporting.

A Mm-hmm.

Q Would it be better if it was compulsory?

A I think that that-- That is a question that I've given a huge amount of thought to, really, because mandated reporting doesn't-- isn't-- happen apart from for NDAP and KSAR and I think that we would need to think about the type of organisation that NHS Assure is and we are there mainly to support the boards and to work in a collaborative relationship with them around the new build and IPC environment.

And I think that we would need to weigh the benefits of mandating against the disbenefits of the potential disruption that that might make to the relationship that we've got with the health boards. I think that there is something about a proportionate response and-- and reporting and I think that we would still wish to maintain our supportive element around how we provide advice and knowledge to boards.

We do manage to tread that line quite carefully around NDAP and KSAR because they're mandated engagement and that sits alongside the reactive work that we are asked to do or the support requests that we receive and we manage that balance quite well, but it is a difficult line.

Q I'm just thinking aloud here in a sense that if reporting in accordance with a particular approach is expected, is there any real difference between the board, a board, reporting as expected and reporting as required? Doesn't add an extra burden, does it?

A No, no. It doesn't add an extra burden at all. It's just the relational aspect of that.

Q Right.

A And, you know, we have a good relationship with the boards and the majority report extremely well.

Q Yes. We'll come back to reporting no doubt later on. Can I just go back for a moment to the 2A scenario and the pathway provision? I've just been asked to kind of put the question, the way the pathway arrangement seemed to work from your evidence is that you provided the pathway.

A Yes.

Q You set out what you thought should be done.

A Yes.

Q But you did not technically check any of the material to make sure it was correct?

A No, we didn't.

Q Given I suppose that the thrust of the point that's being put to me is that, well, given the situation at the time with the Board, is that not something that really should have been done? That you should have been doing the checking, not leaving it to the Board to say, "Well, we've done whatever," and you say, "Well, that's fine, provided you tell us that you've done that you can reopen."

A I think that I probably need to clarify. So, the pathway provision was a series of questions or phrases or comments that GGC would then have to provide evidence that they had complied with.

Now, some of that would be, we would ask them for further information or another report on, or information that they'd complied with that in a timely way or that they were doing flushing and dosing in a particular order, but we wouldn't go on site and check that that had been done. That would never be part of the KSAR process. It does tend to be a tabletop process around the gathering of information. We would then go back to the Board if there were gaps in that information or it didn't provide what we felt it should.

Q Well, with the benefit of hindsight and given the position of the Board at that particular time, should they really have been left to do that themselves? Should you not have taken control of that process?

A We weren't asked to take control. We were asked to support them.

Q I understand that. I'm just wondering whether-- You know, your position, as you've made clear, is you did what you were asked to do and you were not in a position to do anything beyond that. With the benefit of hindsight----

A Although we did offer.

Q -- do you think it would have been sensible to do it?

A Well, we did offer. You know, Annette, in her email of 21 December as you mentioned earlier----

Q January.

A January. I don't know why I keep saying "December". Apologies. You know, we offered to go in and look at other areas.

Q Thank you. Let's move on if we can. So, going back to your witness statement, paragraph 37, to an extent you pick up in that paragraph the relationship point that you have just explained to us. Can I ask you about another possibility?

A Yes.

Q I asked you earlier about how you would deal with someone who paid lip service to, perhaps reluctantly, your processes and you explained how that would be dealt with. Another phrase

that's been used by some participants in this Inquiry about NHSGGC was, well, "They always know best". How would your mechanisms cope with a board if that was correct? You said "X," but they say, "Well, very interesting, but we know better."

A Then if they did that and the mitigation that they gave us was not compliant or didn't meet legislative requirements, then we would potentially give them unsupported status on either an NDAP or a KSAR and if that was the case that would go through CIG but of course there are escalation points before that so we would have the conversation first of all with the people, the team that are involved in that process, be that a KSAR or an NDAP. That's a multidisciplinary team.

They would have the conversations with the Project team around why they felt that that was an issue and then if needed that could be escalated to the head of service or the associate director for engineering or Property Capital Planning or IPC, depending on what that issue may be.

And then if we still couldn't understand or there was an intransigence around a particular point of view then that could be escalated to myself, and I would then have a conversation with probably the SRO for that project within a board,

and that would all happen before we got to the unsupported status through the Capital Investment Group.

Q I wanted to ask you this because questions have arisen from time to time in the Inquiry about the word "assure". How do you assure something? Of course, for better or worse, you've got it in your title.

A We have.

Q One of the challenges I want to put you to get your comment on is that if the use of "assure" in the title of your organisation creates the impression that you can assure everybody that it's all correct, that perhaps goes a little further than what you're actually doing, does it not?

A I think that our role and remit is very clear about the engagement that we have with a trust around a healthcare build or a refurbishment. I think assurance is one of the aspects that we cover around compliance with legislation and guidance. Would I have called us NHS Scotland Assure? I'm not sure, but I came into the organisation when it was already named.

I think that we do give assurance around compliance. We are also a help and support mechanism for boards when they find that they have got issues with their build environment. We don't take away their responsibilities, but we would

help support them to make sure that they can fulfil their own responsibilities.

Q I understand your answer and I'm going to ask you later about any changes that might be made. I've asked you about mandatory reporting already. I suppose the question which your answer raises, and you've said very much the same thing in the paragraph that we're looking at – you provide reassurance, you provide support and so on so forth – is if I say to you, "Ms Critchley, can you assure me that X has happened, that X is correct, that X has been done?" When I put a question like that to you I probably mean, you know, "Can you guarantee that to me? Have you checked yourself?" and that might be going a little further than you actually do. Is that fair?

A I think that we would check that the Board has the mechanisms in place to-- to ensure that they are compliant. We would point them in the right direction of compliance and if they had a derogation we would support them in how they mitigated the risk therein but, as I've said, a lot of our work sits outside the assurance service that perform the KSAR. We have property sustainability capital planning, we have FM Services, we have ARHAI decontamination collaborative that's across NHS Scotland.

There is an awful lot of work that we do that is outwith that, and we are able to pivot our resources to meet unusual demands.

So for instance, our property sustainability and capital planning division now are supporting the Scottish Government with the whole system infrastructure plan, which is the capital plan for the next few years, and they have also pivoted their work to support the audits of RAAC in NHS Scotland and are-- have commissioned and performed a number of audits around what we would need to do around that. In order for us to be able to do that, we have to be able to pivot our resources to what is important outside of the healthcare build as well.

Q Thank you. Now, you, I think in a previous answer, mentioned the way KSAR works under which you can create an unsupported proposition.

A Yes.

Q And I think you go on to deal with that at the foot of page 2 through 7 and then NDAP which is the design approach. Is that right?

A That's right.

Q Yes. NHS Scotland design assessment process?

A That's right.

Q And you reference at the top of page 238 the various documents, in which you say, "Well if you want to find the various places where we're entitled to do this, that's where you look." The latest

in that list is the DL letter in 2023, which, as you quote, says, “Don’t open to patients until you’ve got a supported status.”

A Yes. That’s right.

Q That seems pretty clear. I just wonder about the end of that paragraph, because again, we’re treading this line between, “We’re here to help” and, “We’re here to police,” perhaps.

A Yes.

Q That’s my phraseology, it’s not anyone else’s, because at the end of that paragraph, you say, “Primary role is to support and provide support and guidance...” etc., etc., etc., but “means we can effectively raise concerns on projects”. Now, am I right in thinking that the way the trend is going at the moment, you can stop them?

A Yes. If we felt that there was something critical within an NDAP or-- an NDAP is at the start of the process, so it’s the design process, so it is part and parcel of the outline business case and the full business case, although we are looking at-- at ensuring that there is no duplication between KSAR and NDAP, and they work very closely together now.

What-- If we found that there was something that was insurmountable that we felt would be a risk to patients and staff, then we wouldn’t give a supported status, and until that-- the Board had complied with legislation or amended, then we would not-- that would mean that CIG would not pass that for the board to be able to open to patients and the public.

Q Now, you’re asked on page 238, have you ever had an unsupported stage crop up, and you say that that has happened. Then you say:

“This status is reported to the Capital Investment Group and is used to inform the group’s decision making to allow, or not, a project to progress... ”

But if your previous answer is correct, the CIG don’t have an option. They can’t proceed unless it’s supported.

A No, it can’t but we would go along to the CIG and give them the technical reasons why that might be.

Q Well, whatever the technical reasons are, if it’s still unsupported, do I not understand the way the guidance now stands is it can’t proceed?

A That’s right but only at handover and commissioning KSAR, so right at the end of a project. What could happen further into the project is that if we had-- say, had some issues that hadn’t been ironed out to outline business case, if there was some issue around a change in clinical strategy or the utilisation of a building, then what we would do is we would do, we would give that a conditional supported status on--

on the Board producing an action plan that we would ensure was completed before we did the FBC KSAR, but there is not that-- that does not happen at commissioning and handover.

Q Well, I'm going to ask you some questions near the end of your evidence about what might or might not be done and how your system might or might not pick up particular issues, but let's for the moment, if we can, move on to a different topic, and that's-- well, move on to, or back to, reporting because there's a tale that we need to make our way through here. The first question you were asked about this is on page 239, the first revisiting of this guidance for reporting. You pinched the point about not being mandated, and I'm not going to ask you about that, again---

A Excuse me. Could I just----

Q Yes.

A Are we going to come back to KSAR later or not?

Q Perhaps only in general terms. Is there something you would like to add on KSAR?

A There is. So, I would-- I'd just like to say that actually one of the four builds that we have been involved with through KSAR has been the Parkhead Health Centre that we've done in collaboration with Glasgow, and that has been a really successful programme of work, and we've been involved from outline business case right through to commissioning and handover, and that building is now open for patients. That's been a really good collaborative process, and we have done-- significant lessons learned from that.

So, we are quite a young organisation, and we take feedback from our healthcare partners really seriously, and we have looked at how that has gone and the feedback that we've had from Glasgow which, on the whole, was excellent.

Q Just so we have some idea of the context, what kind of development was this?

A It was a health centre.

THE CHAIR: A GP----

A Yeah.

THE CHAIR: A GP health centre?

MR CONNAL: So, providing GP and----

A Community services.

Q -- associated services?

A That's right.

Q So, sometimes opticians and physios and----

A Yes.

Q -- similar? Is that the kind of thing we're talking about?

A It is.

Q Thank you. Well, thank you for updating us on that. I was just going to

go on to----

THE CHAIR: Say you carried out a lessons learned exercise, did you document that in any way?

A Yes. Yes, we have-- we have a presentation around that, and that would be available, but I think we're going to talk about training later on, are we?

MR CONNAL: We are.

THE CHAIR: Right. It just occurs to me that if-- I mean, you've made reference to lessons learned, and if there's a convenient document, you might provide us with that---

A Yeah, absolutely.

THE CHAIR: -- together with the emails. Thank you.

MR CONNAL: Yes, I'm going to come back to the general question of how the NHS system in Scotland now takes on lessons learned and the various steps in that a little later in your evidence. I just want to deal with reporting. We start to deal with that-- We've dealt with the question of why you say mandatory reporting, compulsory reporting might be an issue.

You go on point out that-- or to remind us, perhaps, that the origins of Assure are actually in the issues that arose at the Queen Elizabeth Hospital and RHC because, prior to that, there was not perceived to be any need for the kind of oversight. Actually, there are some questions in the succeeding paragraphs which are probably repetitive of ones we've asked about the short life working group and so on.

Actually, just on that KSAR, one can understand that every minor piece of work couldn't possibly come through NHS Assure because you'd be overwhelmed.

A Mm-hmm.

Q I wonder if-- particularly given the experience of 2A, which was a relatively costly piece of work, albeit not outwith the Board's limits, have you given any thought to whether the level at which your involvement becomes compulsory might be lowered?

A We are looking at that in response to our work around the whole system infrastructure plans. So, each board was asked to pull together a capital programme around the whole system infrastructure. Our Property Capital Planning team supported them through that process, and all of those reports went to Scottish Government. We are working with the Scottish Government team to assess those reports and asks around capital infrastructure.

There are probably about 80 projects that have been identified through that process, and we have estimated that probably about 30 of those require our input. Not all of those meet the criteria for a KSAR. So, we are looking at how

can we support them perhaps in a slightly different way. So, it may be just something as simple as subject matter expertise around a single issue that might have been covered by the KSAR; so, via IPC, medical, gas, whatever. Some of them, we are already involved in the project. So we are already giving support, and one of those projects we feel would benefit from an NDAP and a KSAR.

So, as we evolve and as situations arise, we are looking at how can we ensure that we are supportive of the most in-need projects.

Q Just thinking through that answer – and I understand that you're explaining an evolving situation – could that lead to some method of identifying, as it were, in advance why, you know, 30 of the 80 might benefit from help and the others----

A Yeah.

Q -- for one reason or another, you shouldn't get involved in because that would then allow participants in the process to know, "Well, if I go and do X or Y, I'm going to have to work with Assure".

A Yes.

Q Is that a possibility?

A I think-- I think it probably is. As we evolve what we're doing and as the capital pathway-- currently, we only have a small number of capital builds, but I think as that opens up and we look at more refurbishment around linking in buildings with clinical strategies and providing services in slightly different ways, we may have to re-look at our engagements and how we make sure that we are involved.

Now, having said that, many of the boards do come to us around projects that they've got ongoing for our support that wouldn't realise a KSAR or an NDAP process, and we are happy to support them through that, but we recognise that, probably in the future, that would evolve and perhaps we wouldn't have the same criteria that we do now.

Q My further reason for asking that question, just thinking ahead, is that the KSAR system-- first of all, it's a process, it's publicly available, it's recognised, and it is buttressed, if I can use that phrase, by consequences----

A Yes.

Q -- as set out in various government letters and so on. At the other end, you have boards approaching you voluntarily for help. I understand that. If you were to change the goalposts – that's my phrase – by moving the criteria for KSAR from where it currently sits, or KSAR light or whatever it was, would that not also require a similar buttressing with not only definition but also consequences?

A I'm sure it would, and we would need to have that discussion with SG, who produced the DLs around when we are engaged or not engaged. I think that that is a-- is a possibility for us, and I think that we already use the principles of KSAR and NDAP in some of the programs that we've been asked to support, be that in a single area – so maybe electrics, ventilation, water, fire – but we would adopt the KSAR principles.

Q Thank you. So, that may be something that's coming over the horizon but isn't quite here yet?

A Yes.

Q Do you think it would be something this Inquiry should encourage to happen?

A I think it may be a natural evolution for NHS Assure. You know, we must remember that large-scale healthcare builds are usually, for a board, a once-in-a-lifetime experience. However, refurbishments and reframing changes according to service delivery are much more common.

Q Thank you. I'm conscious-- I've been looking at your witness statement, and I think there are a number of issues that have sort of cropped up already. I'm not going to go back over them again, at least not at the moment. So, can I take you forward to page 244, where we start to come to a point which I wanted to ask you about because, to some extent, it has moved on since your witness statement was----

A Yeah.

Q -- prepared as well. Now, this starts by asking about meetings that had been taking place between your colleague, Laura Imrie and Sandra Devine. We have heard, obviously, from Ms Imrie but, given that you're, I suppose, in the hierarchical ways, you're senior to her, I'd just like to at least take this briefly from you. You were asked do you think these were a good idea, these meetings. I think at the top of page 245 you said, "Yes, [you] found them helpful". Is that right?

A Yes.

Q Then you were asked why did they stop, and you were asked do you think it's justified stopping them. As I understand it, you say, "Well, I don't know why they were stopped, because I was never told". Is that right?

A That's correct.

Q But you found them helpful?

A Yes.

Q I think I'm right in picking up, from the foot of page 245, that the cessation of these meetings was reported, if that's the right word, by Laura Imrie to Colin Urquhart. Now, I'm not sure Mr Urquhart's role has cropped up anywhere in our discussion. I might be

wrong about that. What does he do?

A He is a policy lead for the HAI CNOD department.

Q What you do in your answer, you say, well, Laura Imrie updated Colin Urquhart during one of their by-weekly catch-up meetings, and then you go on at the top of 246 to say, in October 2024 Scottish Government issued a letter reiterating its expectations on HCAI reporting. Is there a connection between the one and the other?

A I think that there was a lot of background to that. So one of the things that GGC regularly asked us about was around the HAI reporting process, and also the roles and responsibilities for IPC. And we had a number of letters backwards and forwards between myself and Ms Wallace around our role and the request for information to GGC. So I think that-- it-- this DL was helpful in as much as it talked about the expectations of HAI reporting to ARHAI and made it clear that that should be in line with Chapter 3 of the NIPCM.

Q Thank you. Some time ago, I think the suggestion was made that the reporting was not being done by GGC in line with that manual and that's something that was subsequently looked at. Is that correct?

A It is, yes. As part of a small short life working group, following on from an exchange of letters from the director general, Mary Morgan and our chief executive and Jann Gardner – GGC chief executive – asked a small group of us to come together to look at their-- I think it was called the-- their "Infection Management Processes Framework" - something like that.

We didn't realise that GGC had a framework at that point and when the ARHAI team reviewed that, we didn't feel that it was compliant with Chapter 3 of the NIPCM and we also felt that it followed the Public Health Guidance, and it cited the Public Health Incident Guidance on roles and responsibilities. However, the NIPCM is the primary source for healthcare infection incidents and outbreaks and should be used----

Q Okay.

A -- as-- as----

Q I'm going to try and slow down the narrative a little bit----

A Okay.

Q -- because I want to make sure that we've at least walked briefly through the sequence in chronological terms because I think this sequence of exchanges that you're talking about are dated in the course of the present year - and, in fact, some of them very recent indeed - and I'm going to come back to these, if you don't mind, in a moment or two. Can we go to 247? Some of this, I

suspect, given what we know now, we can take reasonably briefly. In Question 49 you're asked:

"In her oral evidence, Ms Imrie mentions concerns in respect of governance structures around carrying out HIIAT assessments and the criteria for reporting infection-related incidents within NHSGGC. Do you share these concerns?"

Then you point out that on January '24 you had sent a letter to Professor Wallace, some of the contents of which you quoted. Is that right?

A Yes. That's correct, yes.

Q You kind of start to flag there the possibility of a difference of approach that is emerging.

A Yes.

Q And you say at the top of page 248 that following that exchange, CNOD-- so this is the policy-- Is this the same as a Policy Unit?

A Chief Nursing Officer's Directorate, yes.

Q Yes. Re-issued a letter on IPC surveillance and so on, reiterating adherence to the NIPCM and caveatting things like, "What happens if there's great pressure at the time?"

A Yes.

Q And then we come back to the point about mandatory or not mandatory, which I will ask you about again. I suppose the next question comes back to this, "Why bother with all of this anyway?" kind of question if you're an outsider to the process because Ms Imrie has noted in the Question 50 as saying:

"[Well] ... as a national body, how can you give assurance that nothing's happening if you're not sure that you've been told anything? "

You say, "Well, do you agree with that?" And the answer you gave is "yes." Now, this is because, as you explained earlier, unless you know what's going on, you can't understand the bigger picture. Is that right?

A That's right.

Q Just explain this to me in a couple of sentences.

A So unless you understand what's happening nationally, you can't understand whether an maybe an outlier for a particular type of infection or outbreak. You can't understand what's happening in, say, a particular unit. So, if you've got a number of infections that are all in, I don't know, general surgery, but actually they're very similar across the whole of NHS Scotland, then you may be able to trace that back to equipment or something, or it may be an environmental issue. If you don't have that information then you can't make informed decisions around what you should be doing around those infections and outbreaks.

Q Thank you. I just wanted to ask you a point that I had probably overlooked when I first read your statement. Can we go to 249, where you're asked near the foot of that page:

"Do you believe [at the time you were writing the statement] there are now sufficient and adequate control systems in place to monitor infections within NHSGGC? If so, why?"

You say, "Well, I don't really know because of the issues over information exchange." Then you say at the foot, and I just want to pick this up in case this is another thing for the future:

"A national surveillance system that enabled ARHAI Scotland to access real time data, similar to that being considered by the Scottish Government, may allow a clearer understanding of Health Board reporting and any gaps in data being shared with ARHAI Scotland."

So, leaving aside the exchanges of views that we're coming to, what's that you're talking about?

A So----

Q So, is this a way of avoiding the need to report at all by letting you find out directly?

A No, I think what it is, is it would be a real-time reporting mechanism, electronic. So, currently, information is collated by ARHAI. We would be able to actually see that in real time as the

Board's report, and that would help to support the national surveillance view. I think that that would be-- So we would be able to consider all aspects and we'd be right up to date.

Q And you say it's currently under consideration, or at least you did when you wrote this statement. Is that still the case?

A It is, yes.

Q Do you know what stage it's got to?

A I don't, but Ms Imrie would-- would have more information on that.

Q Now, the next question you asked seems to be something about whether ARHAI should be involved in this reporting process at all. If we go to page 250, you see the answer near the top of the page:

"I understand that NHSGGC has, on several occasions in this Inquiry, expressed the view that incident reports should come directly from health boards as opposed to through ARHAI Scotland, to ensure accuracy."

Do you agree with that proposition?

A No.

Q And why not?

A I think that because the health boards report into ARHAI who are able to collate information across the whole of NHS Scotland, so-- and we have the staff who are very skilled in that area. We

have a large number of healthcare scientists who are able to interpret data and look at trends and themes and analyse those.

I think that having us review all of those infections helps the process around-- we're independent, so we can provide impartial advice. We think about evidence base and how we-- we should respond. A centralised approach helps the standardisation of reporting. So if you have 14 different boards reporting in slightly different ways, you would then never be able to aggregate the data or think about what that actually means as a whole.

And I think it also encourages transparency and accountability because those reports come through, ARHAI collate it, sent on to CNOD. I think that it helps to inform policy, and you can see the number of changes to the NIPCM over time. They been supported by-- by the process of understanding what is happening holistically across NHS Scotland.

Q Thank you. The issues that arose with NHSGGC seem to have been around an internal SOP----

A Yes.

Q -- for monitoring and which, in your view, your and Assure's view, didn't align with the NICPM Chapter 3. Is that right?

A That's right, yes. We weren't aware of the SOP and then when we were made aware of it, Version 1 and 2, we didn't feel were compliant with the NIPCM Chapter 3 because they had a stage of assessment prior to the HIIAT assessment. Subsequently, GGC have produced Version 3 and, following the short life working route that we mentioned a little bit earlier, Version 4, both of which we think are compliant with the NIPCM reporting now.

Q Now, the process, as I understand it, that has ensued is in part dealt with in your witness statement because what you do in your witness statement, you say on 251, is you pick up the issue of the internal SOP.

A Mm-hmm.

Q You explain raising concerns about it. There seemed to have been a debate as to whether some other document should have been the guiding document other than the NICPM----

A Yes.

Q -- which you didn't think was correct.

A No, that was the Public Health document.

Q The Public Health document?

A Yeah, which very clearly states that healthcare associated infections should be managed through the NIPCM.

Q Yes. So, these exchanges, as

I understand it, then continued to the extent that Assure had a view on this; NHSGGC, at least at that stage----

A We did.

Q -- were producing a slightly different view. Is that right?

A Mm-hmm.

Q Now, let's just then look at the communications just so we get them dealt with. Can we look at bundle 52, volume 5, page 142? Now, to some extent, the precipitating factor, if not the original debate, was around some Cryptococcus reporting, which I don't really want to ask you about in detail. But that's one of the early exchanges, is that right, in the sequence that we now know about? So can we go to 144? Now, who's this coming from? Caroline Lamb?

A That's right.

Q So she's the-- well, we've had a debate with Mr wright about whether we should call him chief executive when he doesn't manage chief executives.

THE CHAIR: That's what our letterhead says.

MR CONNAL: I know. This is from the chief executive, Caroline Lamb, to Professor Gardner, the current CEO----

A That's right.

Q -- of the Board, which starts essentially by saying that NHSGGC did not report as would be expected. Is that correct?

A That's right, yes.

Q And explains what's happening. I mean, can I just pause there and just ask, am I right in understanding from your witness statement that NHSGGC is the only one of the boards that you've had this issue with?

A I have had one other issue that has been escalated to me around reporting and that was a particularly complex environmental issue that required engineering and IPC support, and that issue was escalated to me. I had a telephone call with the director of estates of the trust, and we sorted that within one phone call.

Q Thank you.

A That's the only other board that I've ever had escalated to me.

Q Thank you. Now, just let's see how this letter concludes on 145. There's a request from the chief executive for some information, including immediate confirmation that reporting of HCAI incidence outbreaks are handled as Scottish Government expects as per DL 2024, number 24, and, in addition, some information to be provided to ARHAI. Now, I'm assuming from the fact that you're copied into that that you were aware of that being prepared?

A No.

Q No. You got it after the event,

as it were?

A Yes. I knew that there were some discussions but I didn't know that they would result in a letter.

Q Right, very good. It was copied to you. So, we go on there from that one to the next page, 146, which is a reply from Jann Gardner to Caroline Lamb to the previous letter where she says in the third paragraph:

"The opportunity to understand with ARHAI the evidence for the suggestion that NHS Greater Glasgow and Clyde has been identified as an outlier would be appreciated [and so on]."

Now, there's an assurance at the foot of the page, and we'll see what it says on 147 in a second, from Jann Gardner that IPCT say they are fully compliant with Chapter 3. Now, that, of course, might depend on how you interpret Chapter 3 or not, I don't know, and then we move on to the next page. I'm not sure what the aim of that letter was, but no doubt we can ask Professor Gardner. It appears to be a response to a letter which demanded certain things to be done ASAP but raising other issues. Again, you would see that at the time, I take it----

A Yes.

Q -- because it was copied to you.

A (After a pause) I think that I probably do need to explain to the Inquiry that, at this point, GGC had produced Version 3 of their standard operating procedure, their IM, which was compliant.

Q By this stage?

A Yes. I think it had been-- I think it had been amended in April this year, although we didn't know because we hadn't seen it----

Q Right.

A -- at that point.

Q Now, I'm not going onto the next page because I'm going onto a different volume. I now need to go to bundle 52, volume 6 at page 48. This is a communication from the director general, chief executive to Mary Morgan, who is----

THE CHAIR: Sorry, my fault, I don't have the reference.

MR CONNAL: So, this is bundle 52, volume 6, page 48, a letter enforcing----

THE CHAIR: Sorry, bundle 52----

MR CONNAL: Volume 6.

THE CHAIR: Volume 6----

MR CONNAL: As opposed to 5----

THE CHAIR: Page 48?

MR CONNAL: 48, yes. (To the witness) So, this is someone else being drawn into the communications, is that right?

A This is my chief executive, Mary Morgan, chief executive of NSS.

Q She's being asked by Caroline Lamb to come on board and help, essentially, is that right? So, can we go on to page 49? Now, what's happened here, I think, is reference is being made to an SBAR which had been sent on by Jann Gardner to Caroline Lamb in one of the earlier letters, in which the writer of the SBAR made various allegations about sensationalising of communications and so on and so forth, and that's been picked up, I think, by the writer here, by the director general near the foot of the page. Is that right?

A Yes.

Q (After a pause) You will see that they-- So, here we have the director general saying:

"It is assumed that the detail provided at the background section of this SBAR provided the assurance in relation to patient safety to the Chair and Chief Executive at the time; as the assessment section focuses wholly on reporting, and comments on whistleblowers, ARHAI and experts appointed to the Public Inquiry. You also note that in May 2025 [if we can go on to page 50], the NHSGGC Infection Prevention and Control Doctors carried out a further review of these cases and did not identify a cluster."

Then, there's a reference, I think, to the updated process that is by now in place, is that what you were referring to a minute or two ago?

A Yes. I think, though, that the Version 2 that's mentioned in the third paragraph of this letter was then superseded by Version 3, which was compliant with an IPCM, and I think that that happened prior to this letter being written.

Q But essentially, what happens is that the director general says, "Right, you and Mary Morgan are to meet and try to agree something here," is that right?

A Yes.

Q Again, you, I assume, are being kept aware of these exchanges.

A Yes.

Q I think it's fair to say that ARHAI were criticised in the SBAR.

A They were.

Q Then, if we can just see what then happens, page 51, which is a short letter basically saying, "We've met and things are being progressed and we've given ARHAI the required information." I take it from ARHAI's perspective, this was now progressing in the right direction?

A Yes.

Q Just to complete the picture, if we then go to bundle 52, volume 7 at page 453, and this is, in fact, a joint letter----

A It is.

Q -- from both the chief executive

of GGC and the chief executive officer of NSS. Is that right?

A That's right, yes.

Q Essentially saying, "We've met. We're going to work on these issues. Here is what we're going to work on." Is that correct?

A That's right.

Q Then, they're going to continue to meet-- in a final document, just to finish the sequence, if I understand it correctly – that we have at the moment anyway – is an SBAR of 19 September, which we'll find in the same volume, so bundle 52, volume 7 at page 483. Now, in this case, as opposed to a "CC" on other people's letters, you're now a co-author. Is that right?

A That's right.

Q Essentially, what you're doing in this document is you're outlining what you're going to try and sort out.

A We are, yes.

Q Can I just ask you generally, when one gets to the end of this process as set out in the SBAR, are you now content with where you've landed?

A We are in terms of the IMPF, so we had some discussion around the utilisation of the Public Health Incidence Guidance and we agreed that, actually, NIPCM should be the primary guidance that should be used, and we were all collectively happy about that and Sandra Devine went away and made amendments to their IMPF, which is now going through their governance process, so we are happy to do that and agree that that is compliant with an IPCM.

We also have looked at improved collaboration between the teams so, following on this SBAR, this work is being-- you know, I'm working with William Edwards, who's the deputy chief exec of Glasgow; Sandra Devine, who's the IPC director; myself; and Laura Imrie.

We are working on some kind of development OD sessions after the end of this week and what we've agreed is that we are going to have some development sessions for the wider teams that will start to look at things like understanding of roles and responsibilities, reflection on reporting processes, collectively exploring high performing teams and how we can move towards that function, and also to re-establish and reflect on the collective values and behaviours that are expected, and we will have some external facilitation for those meetings.

Q I need to ask you one thing.

A Mm-hmm.

Q Ms Imrie, I think in her evidence, says, "Well, all this reporting process depends on people trusting the other party to do what they're meant to do." Here, you have a board which was

prepared to go to the extent of sending a letter from chief executive level including criticism of your organisation as well as of others. Based on where you are now, does that necessary trust relationship exist?

A I think that everybody in this process believes that they are doing the best that they can for patients, and I hope that the facilitated development sessions will allow more open communication and understanding of each other's roles and responsibilities because I'm fairly certain that there was not clarity around that. For instance, I don't think that GGC understood that some of the questions that ARHAI come back with have actually come from the CNOD HAI Policy Unit who have asked us to ask those questions.

I think that we will-- we hope to move forward positively and ensure that the relationship in the future is a positive one, and I think that the changes in the IMPF volume 4-- Version 4, will ensure that reporting is as it should be. I think trust is something that one builds over time. We are working very well as a small short life working group. I think that the development sessions can only help to improve that relationship between ourselves and GGC on reporting.

Q Thank you. You can take that one down, thanks. (To the witness) I might just see if I can dispose of a non-controversial topic before we rise for lunch, perhaps two. In your witness statement at page 256, you're asked about something called a "common data environment", which is focused, I think, on how digital technologies can best be deployed, and it starts by pointing out that the independent review into NHSGGC suggested greater use of digital technologies and so on, and you tell us later in your statement that Assure worked with stakeholders to try and produce something on a presumably digital data environment----

A That's right.

Q -- and try and find out how you could best progress the matter.

A Mm-hmm.

Q As I understand it, the initial reaction was, "Well, very interesting but we've got priorities up to our ears. We perhaps can't focus on this at the moment, and it didn't get very far. Is that fair?

A I think that-- I think that there needs to be just a tad more context put into that because the CDA, or the AIMS model, which was the Assure Information Management System, which was, which is a common data environment, was procured in 2021 and the roll-out was during COVID. So I think that there was less of an uptake than there would have

been had it been at a different time. It's-- It's also not mandated, so boards don't have to use it.

Q Yes, and is there work continuing on this question of trying to improve the digital availability of information?

A There is. So, we have just procured this year a new system which can help with the CDE. It will contain asset information, so things around when you need to do planned maintenance, if a piece of equipment is to record temperature, then if it goes outside those parameters, it could alert. There is-- and it'll provide a golden thread around when things were brought into commission, when they should be reviewed, when they should be replaced, but also it could hold-- it could be a repository of all of the information of that asset over a lifetime.

So, for instance, with the whole system infrastructure planning that we're doing, if every board had had a CDE or had utilised AIMS in the right way, then we would have had a very significant piece of information around all of the healthcare built assets that we were then looking at. It is a normal thing that is done during construction. So, you can have a supply chain CDE, so one of your partners who is helping you to construct a building will have that information, but unfortunately when they depart a project they take that with them.

Q Is this mainly focused on maintenance of the estate?

A It can be. Yes. It can be but it can also talk about utilisation of buildings and what they're there for, what-- what the parameters within that building should be and whether they are exceeding those parameters or not.

Q So what, as of today, is the state of play on improving the digital availability of that kind of material?

A So we re-procured in 2025, and we've got a new system that we're just about to start launching. We will then progress that with development, guidance, tools, learning opportunities for the boards to engage to utilise that as part of their digital estate assets.

Q So this isn't focused just on NHSGGC; this is general?

A No, no. This is across NHS Scotland.

Q Thank you.

THE CHAIR: Is this a commercial project which will be licensed to the various boards or are you the proprietor?

A No, we're not the proprietor. We purchased this through procurement rules.

THE CHAIR: Right.

A But we would probably produce the training requirements and the guidance on usage and any other

tools that might be required for the boards, and we would facilitate that.

THE CHAIR: And each board would obtain a licence?

A Yes. Each board would populate it. Yes. Well, I'm not actually entirely sure on that. I don't know whether we would have a licence that we then----

THE CHAIR: Which you could then----

A Put----

THE CHAIR: Yes.

A Yes.

THE CHAIR: And share. Thank you.

MR CONNAL: My Lord, this might be an appropriate point to rise.

THE CHAIR: Well, we'll take an hour for lunch, so can I ask you to be back for five past two?

(Adjourned for a short time)

THE CHAIR: Good afternoon, Ms Critchley.

THE WITNESS: Good afternoon.

THE CHAIR: Now, Mr Connal.

MR CONNAL: Thank you, my Lord. (To the witness) Could we have a bundle 52, volume 5, page 150, please? Now, this is the SBAR that accompanied the letter from the chief executive of NHSGGC, which contains the passage which many people have found:

"... attention drawn about multiple statements made by whistleblowers, ARHAI colleagues and experts criticising NHSGGC compliance, opinions based on incomplete information biased by people's personal beliefs and interests trying to sensationalise the fact this is a case of cryptococcus. It must be found or linked to the new hospital."

Now, the question I think I have to ask you, in light of your evidence just a few moments before we broke, is this. One can see from the exchange of letters that we looked at earlier that letters have been exchanged-- let me say-- say action has been taken and some form of order has been, well, to my reading, imposed among what's happening. You've then gone on to explain what happened next.

Now, the kind of discussions that you were explaining to us, reflecting on collective values and so on-- given that, only a matter of a few months ago, the IPC system at NHSGGC generated that SBAR and the chief executive thought it appropriate to send it to Scottish Government, I've been asked to suggest to you that the kind of organisational development and discussion process that you've engaged in is likely to be wholly inadequate to resolve the problems. What do you say to that?

A I think that at the point that this

was written, the IMPF was in Version 2, which actually wasn't compliant with the NIPCM. Since this SBAR was written-- I understand it was written in November last year, November '24, Version 3 was issued in April 25, and that is now compliant. So, some of the issues that it talks about-- the difference of opinion between GGC, IPCT, and ARHAI on interpretation of the guidance and the NIPCM, I think that we have now come to a common understanding what that is, and their IMPF has changed, again, around both reporting and HIIAT reporting into the ORT and the-- and also the primary literature for an IPCM-- for their IMPS is now the NIPCM and not the public health guidance.

THE CHAIR: I appreciate that this is sent by the chief executive. Do we know anything about the authorship of the SBAR?

A I don't, no.

THE CHAIR: Right. Now, in responding to Mr Connal, you have essentially said the difference of opinion in the construction of the National Infection and Prevention Control Manual has been-- a common view has been arrived at, but can we look at the paragraph which Mr Connal read under, "Assessment"? Now, there have been multiple statements and-- attributed to whistleblowers, ARHAI colleagues, and experts appointed by the Inquiry criticising GGC compliance. Now, the next sentence goes on:

"All these opinions have been based on incomplete information biased by people's personal beliefs and interests, trying to sensationalise the fact that there is a case of Cryptococcus."

Now, just asking you at this point to speak on behalf of ARHAI colleagues, is there anything that you know might provide any basis for the notion that ARHAI colleagues' opinions are biased by their personal beliefs and interests?

A What I would say is that I believe that this is not based on fact, it's based on opinion, and I think factually, ARHAI are impartial, and they report on the information that they receive, and they do so in a professional manner.

THE CHAIR: Right. Thank you, Mr Connal.

MR CONNAL: Are you aware of any basis for the suggestion that ARHAI colleagues were trying to sensationalise anything about Cryptococcus?

A Absolutely no basis. We didn't know about Cryptococcus until it was mentioned in the last diet of hearings.

Q So, if we come back to the question I asked-- because the gist of the question, I think you'll understand very well, is that this document, which appears to be a statement on behalf of NHSGGC

IPCT-- it doesn't matter which individuals perhaps issued it because you see near the foot, "NHSGGC IPCT is confident that we are complying", so it seems to be written by them.

A Mm-hmm.

Q Given the kind of things that have been said there, I think the point that I've been asked put to you is that-- to assume that the kind of approach, attitudes, and the like which might be said to be evidenced by this communication are going to be resolved by organisational development discussions is naive, possibly naive in the extreme, because it's not as if this is 10 years old. This is relatively recent.

A And I would hope that the type of discussions that we will engage in, that will be facilitated, would help us to overcome some of those views. I think that we will-- I don't think that anybody in IPCT thinks that they have come to work to do a bad job. I think that they think that they have followed the process.

However, we do understand that the concerns that we had around Version 1 and Version 2, which we hadn't seen till very recently, did not follow the NIPCM. I think that now we are clear that the NIPCM-- we now have a joint view around what that means. I think that that will help to facilitate some conversations. But I'm not saying that it will be easy, but we do need to develop a really good professional working relationship.

Q Thank you. We can take that off the screen. Can we go back to your witness statement? We'll deal with another topic, and I want to pause a little bit on this because this Inquiry has one term of reference which is focused specifically on learning lessons.

Now, in your witness statement, you mentioned one or two other organisations that have been set up in the hope of creating lesson learning opportunities and the extent to which they did or did not prove successful, but I'd like to focus on the Assure position. I think that probably starts on page 263 of your witness statement. As you'll probably understand, the concern of the Inquiry is to focus on whether there are processes which will ensure that lessons arising from construction projects in particular are picked up, are communicated, and are then, I suppose, effective in getting messages across.

I think you actually start by mentioning that you've listed a lot of the events that you've held and the topics for these events in an appendix to your statement. Is that correct?

A We have. Yes.

Q A very large number of seminars on a range of topics.

A It is.

Q Now, this no doubt follows on from earlier evidence that you gave us about the fact that part of NHS Assure that we've been focusing on is only one part of your job. You do a lot of other things as well. Now, you mentioned at the foot of page 263 something called the Learning Network. Now, what's that?

A So, the Learning Network is a network that we've developed since NHS Assure came into being and it is-- it will present a range of topics over recent years. It is available to all of the boards. Some of the content of that is available for view, and we look at topics that may come through a range of different options. So, they may come up from one of the advisory groups to NSFG and we are responsive to what the boards might ask us to look at. So we've done a number of seminars and learning events around topics. There are a large number of them though they're in the appendices.

Q Yes. So for instance if we go on to page 264 just to take an example, there's one there in July '22, the subtitle of which, "What I wish I'd known - lessons learned from KSAR Initial Agreement projects."

A Yes.

Q Is that the kind of thing you mean?

A It's exactly the kind of things. So, you know, there's another one a little bit further down that talks about "OBC – Lessons Learned" and "FBC – Look Ahead". There are all sorts of-- We don't only look at the builds. We look at sustainability. We look at, you know, quality and construction around property and capital planning. There's all sorts of things that we look at. We also include ARHAI, which is quite unusual because we look at holistically across the healthcare build environment.

Q I see you have a national conference.

A We do.

Q And does that include the kind of lessons learned topics on its agenda?

A It will do. So, we've had two conferences since I've been in post and one of them, the theme was excellence in the healthcare built environment, and the other one was quality in the healthcare built environment. Where we're quite unusual is that we have a significant IPC proportion of that conference. So as well as doing----

THE CHAIR: I just missed that. Did you say a large IPC component----

A We do, yes.

THE CHAIR: Right. Thank you.

A So, we have a look at-- at topics holistically. We bring together national and international knowledge and I think the difference for us is that we do include that IPC clinical element. So that

conference is also useful for IPC staff or for clinical staff who may be involved in a build, and the feedback that we've had from that has been really, really positive, and it is a helpful mechanism to get people together to talk about topics.

Q Am I right in understanding from page 265 that you also present through other groups?

A Yes. Sort of lessons learned topics. Is that right?

That's right, yes. So we have a lot of opportunities to disseminate training and lessons learned. We've got formal training sessions where we do things like HAI-SCRIBE training for boards. We have workshops around things like adaptation planning for sustainability for boards. We've got drop-in sessions which might be on utilisation of something like our AIMS system or-- or things like that. We also do presentations, so to the National Infrastructure Board or to the Capital Investment Committee or to NSFG around topics that have come up. So, we've had a piece around helicopter landing sites, things like that.

We also do informal training, spotlight sessions, information sharing protocols. So we-- we may put bulletins around things that boards might want to know. We have stakeholder groups as well and we do formal training around-- in fact we've just done some formal training around IPC KSAR surgery. So we've done that around the new build at Monklands. And then we do toolbox talks. We have some animations around handwashing and understanding IPC considerations in water systems.

Q So, toolbox talks, are they on site delivery of----

A Yes. They can be, but we are also looking at how we capture that either by Teams or video, and what we're also doing is we are now pulling together a SharePoint site where we will put all of our resources – so all of our training opportunities, all of our bulletins, all of teams – and that will be available on a SharePoint site to all of the boards within NHS Scotland and that hopefully will help to support them if they've got a particular issue for something.

THE CHAIR: Help me with this. SharePoint is a digital – I'm going to use the word "facility" because I don't have a better word – which is available to certain specified users?

A That's right.

THE CHAIR: Right.

A And we would make that available to all users within NHS Scotland including IPC teams.

THE CHAIR: Right. With all users within NHS Scotland?

A Mm-hmm.

THE CHAIR: Right.

MR CONNAL: Just picking up one or two other points. At 265 about two thirds of the way down you say:

"We have also published a lessons learned paper from the work undertaken by the Interim Review Service."

What's that?

A Yes. So, we did a lessons learned paper when we were coming to inception and we were starting off as NHS Assure, and that talked about the Interim Review Service and what we could do to develop further for the KSAR process. We also have-- Within the single disciplines, we now have a Lessons Learned document that deals particularly with water and another one on ventilation that is in production.

Q These are separate learning documents as far as I can understand it.

A Right.

Q What would be done with them once they're ready?

A Well, if we can get the SharePoint site up and running – when we get it up and running, not "if" – we'll be able to put out push notifications around new things that have been put onto the site, but what we would do with these particular ones is that we would probably take it through the NSFG structure and make sure that the Scottish Engineering Technology Advisory Group were able to access that and could disseminate it then to their members.

Q Right. So, that would mean if you were on your subscriber list for your SharePoint, you would get a notification?

A Yes.

Q For a new paper.

A Yes.

Q "Ventilation in Healthcare – Lessons Learned" or whatever the title is.

A Yes.

Q That that's the way it would work?

A Yes, it is.

Q And I think you were saying you would go in effect to the engineering external sources and say, "This paper is also available to you."

A Yes.

Q And so far the feedback you've been getting from boards is positive?

A It is, yeah. We've done some-- We've done some feedback and we've— the-- our average feedback score is 4.3 out of 5. So we're getting really good quantitative data as well as qualitative feedback around our training opportunities and, as I said earlier, we've done a KSAR lessons learned in June 2025 for the Parkhead Health Centre project with GGC.

Q Can we go to 267, which is still on the same topic? You say in the first full paragraph there:

"NHSScotland Assure have

identified an opportunity to further enhance this learning..."

Now, just tell me what you're telling us about there. What's that about?

A It was just about us-- how we are utilising some of the lessons learned, and we tend to be quite NHS-focused. We're actually thinking about," How do we expand that to include those private sector that are on our frameworks that provide services to our boards?" and thinking about, "How do we then embed them into that training and learning as well?"

And when we do our KSARs-- so, when we start a KSAR process for a new build or a refurbishment, just before the OBC stage we will do a lessons learned with the Board around similar projects and what other boards have found for us and we also had a number of sessions at both of the conferences around lessons learned from those boards that had been through the process.

Q And if we go further down that page what we find there is you're discussing in answer to a question about, well, what opportunities of staff to advance their knowledge, a list of different pieces of training that either you have delivered or in the course of delivering. Is that right?

A Yes. Yes.

Q If you're asked, "Well, looking at the project this Inquiry is focused on, what have you done about lessons learned from this project?", is that all covered by what you've told me today?

A Yes. Yes. Everything would be wrapped up around what we've learned as a whole, but particularly with some of the lessons learned from both Edinburgh and Glasgow.

I think it's important for us to be flexible and to listen to the boards around their experience as well and to use that to inform how we then deliver services in the future and how to increase their understanding of the areas that we might ask them about because, as I said earlier, in the health boards, you may only have one large build in their lifetime, in-- in somebody's career lifetime. Therefore, we need to be able to support them in the right way to understand what their responsibilities are and how we can support them to deliver that.

Q Can I just ask you one question, which isn't in your witness statement, because you weren't asked about it before? One of the topics that kind of cropped up – as some of these things do tangentially – earlier in the Inquiry, was that in some respects estates staff and IPC staff have responsibilities that link one into the other, or overlap or whatever phrase you want to use, but questions have arisen as

to how much Estates know about IPC how much IPC knew about Estates. Is that on your horizon at all?

A It is and some of the things that we've done with other boards is to ensure that they've got that not only clinical representation because, actually, right at the start of the process, it's important that your clinical strategy aligns with your build strategy, but also that IPC is involved right from the start of that process because it isn't just about being a build, it's about an environment where patients are treated and staff work.

So, I think that that's probably where I've got the benefit of having a clinical background, so I can understand that actually that is equally important as getting the four walls right. So, I think that we have a unique model within the devolved nations, in as much as we have IPC involved right from the start of a process, and we would advocate that for a board.

Q Thank you. My Lord, I'm conscious my Lord had a particular interest in this topic. I'm proposing to move on from it. There's more in the text, but I'm not sure whether my Lord has any further questions on the topic of learning?

THE CHAIR: No. I mean, clearly there's a lot of material in the statement, which I think will bear re-reading.

MR CONNAL: I'm obliged. (To the witness) I'm going to come now, kind of, almost full circle in a sense back to what you do and what do you not do----

A Okay.

Q -- because, as you can probably understand, the whole issue is of interest to a range of participants in this Inquiry. If we perhaps introduce it by going to page 275 of your statement, and we find there a question:

"69. In the event NHS Scotland Assure offer support to a health board and it is refused, what powers of intervention, if any, do you have?"

You say, "Well, we're not a regulator", and we come back to your point about being supportive and helping and so on. You say you've no powers of intervention other than in the context of unsupported, and so on, on NDAP and KSAR.

A Mm-hmm.

Q So, you're then asked on page 276, inevitably, "Well, would it help if you could intervene". I think it's fair to say that that's not talking about helping you. We're talking about helping the outcome if your body could, in appropriate cases, say, "No, that's not good enough. Do X or allow us to do Y". Am I right in thinking your answer to that is-- it would be, you think, problematic because of the relationship you're trying to operate in?

A I think that it wouldn't be

appropriate for us to be some kind of a regulator or have intervention powers because our relationship with the boards is built on collaboration and trust. Now, they will come to us if they have an issue with IPC or with engineering. I'm not so certain that they would be so keen to approach us if they thought that we would then go and inspect them or give them-- you know, not support them, but actually mark their homework instead of working collaboratively to make sure that that was-- the problem was sorted.

I think we've built a relationship with our subject matter experts such that we do get approached with regularity by the boards. So, we have a new commissioning process which is out with the new build process, and we have, on average, 60 asks a year. That can range from a small piece of work that may take a few to pieces of work that may take months to support a board with. I think that, currently, it is ultimately up to the boards whether they take our advice or not, but we do have a long-standing relationship with them, and they do come to us to help them-- to help them with their build environment.

I think it's because they require our support and expertise but they also trust that we will be able to provide some kind of a solution or support them into coming to a solution that might mitigate the risks

or the issues that they've discovered.

I think that we do have a route for escalation. So, if we find something that we are unhappy with, and you talked about intransigence earlier, then we do have a route through which we can escalate concerns up to SG, should that be necessary, but I think that that has been a very rare occurrence. In fact, I can't remember a single one where we haven't managed to solve a problem before it's got to that stage, and I think that there would be something about strengthening our role around providing a supported or unsupported status for a live healthcare build, but I think it's quite difficult for us to be involved in every healthcare build.

So, for some of the smaller capitals and projects, such as we discussed earlier in the whole system infrastructure planning, 80 odd projects, 30 that might require our support, we don't have the capacity to deal with another 50.

Q Mm-hmm. Well, that may be a slightly different question, in the sense that we discussed earlier whether there might be benefit in-- I think I called it "KSAR lite". Please don't take that as a title because I just came up with that just now but the idea that something similar might be applied to a level of project which currently does not qualify for KSAR. So the 30----

A Yes.

Q -- if I just take your list for one reason or another, where you don't currently have a process and a formal process to do that, and I think you accepted that was something you might come to.

A Mm-hmm.

Q I think the question we're kind of coming back to is, well, who is it that is going to say, "No, that's not acceptable" or, "Yes, you must do this" if it's not you?

A And I think, in a way, we do have that capacity. So, the NDAP process, if that is unsupported, then the planning stages of a project would not move forward to construction. If we had a project that was in construction and it failed its commissioning or handover KSAR, then it would not be allowed to be occupied. So, I do think that we do have the capacity to do that. It's around the smaller scale projects that we aren't involved in that we would have no knowledge.

Q I have to come back, I'm afraid, to a question I probably asked you earlier, so apologies for repeating it, but there's a temptation perhaps arising from your title or from some of the work that you've done already to go out publicly and say that NHS Scotland Assure provides assurance that the healthcare built environment is safe. Now, given the way you very carefully explained what you can or can't do and, in some cases, what you didn't do because you weren't asked, is that overstating just what you can achieve at the moment?

A I think if you take it from that sentence, then we are not able to assure everything that happens within the healthcare built environment in NHS Scotland. Where we do have a role to play is within new builds and refurbishments, and I think that, as we discussed earlier, the whole system infrastructure planning process may well result in us having a different type of intervention or engagement with boards.

Q I may have missed this earlier. Did I pick you up-- or maybe I didn't. Did I pick you up as saying that you were doing training on HAI SCRIBE?

A Yes.

Q Because one of the issues that has been----

A Yes.

Q -- of interest to the Inquiry----

THE CHAIR: Sorry, I just missed that. Training on----

MR CONNAL: HAI SCRIBE.

THE CHAIR: Yes.

MR CONNAL: (To the witness) One of the issues that the Inquiry's touched on is: was it done, when was it done, was it adequately done.

A Mm-hmm.

Q Is this a recognised issue you're looking at?

A No. So, we do do refresher training for boards. We're happy to come along and deliver HAI SCRIBE because during the lifetime of a build, people will change jobs, new people will come in. We're more than happy to go out and deliver training for any board who may or may not have a project ongoing. I think that we've delivered 57 HAI SCRIBE training opportunities in the last-- I think since 2018.

THE CHAIR: Sorry, 57 opportunities in the last----

A I think since 2018.

MR CONNAL: I'm trying to think of the----

THE CHAIR: So, that would be your predecessor organisations as well?

A Yes.

THE CHAIR: Yes. Sorry, Mr Connal.

MR CONNAL: I'm trying to think of whether the processes you've been describing might, or would, have picked up the kind of issues that the Inquiry has been looking at. I know we're then getting into the realm of the hypothetical.

A Yeah.

Q One of the discussions the Inquiry has had is around about decisions to derogate from guidance taken in a period very shortly before the signature of the contract by the NHSGGC chief executive.

A Mm-hmm.

Q Now, on the face of what I've picked up, none of your processes would actually have engaged at that stage, at the contract signature stage.

A The NDAP process would. So, the planning process would look at the plans for a build. An outline business case, they may be fairly fluid because perhaps the clinical strategy hasn't been nailed down but by FBC, then, the-- the planning part of the build should be baked in.

THE CHAIR: In what sort of detail?

A In quite a lot of detail. So, outlined business case, obviously less detailed. Full business case, we should have a huge amount of detail around what the build is intended for, the links to clinical strategies, the type of rooms that are required, what might be in those rooms, the flow of patients, all of that sort of stuff should be available.

THE CHAIR: I've read the full business case in relation to the new hospitals. I don't pretend to have mastered every detail. I do accept that there are references to the aspirations and benefits that are anticipated from the project. I take entirely your point that it's more detailed than the outlined business case but if we take the example of

ventilation specification, I don't think it goes to that detail. Would I be right about that?

A It may well go to that amount of detail in as much as, "This space is going to be a theatre, so would require this type of ventilation, and that would require this type of ceiling, that would require access." If you had a HDU or a Haemato-oncology ward, you would know that there would be a requirement for a greater ventilation. Therefore, you would have to ensure that your ducting was of the right size and construction. So, all of that should be available at that point.

THE CHAIR: Let me just press you on this a little. As I understand it, Scottish Government gave perhaps quite detailed guidance on what should be contained in the full business case. Now, is your understanding that these requirements go into the degree of granular detail which I'm putting to you? In other words, the ventilation specifications of specialised units?

A I'm absolutely at the edge of my knowledge now, so I would have to defer to my colleagues in Property Sustainability and Capital Planning to answer that fully.

THE CHAIR: Thank you. Mr Connal.

MR CONNAL: My Lord. (To the witness) I'm just trying to kind of work my way through some of the possible areas. The point I was making, I think, was that we had evidence that a decision to depart from SHTM 03-01 guidance was made, let's say for the sake of argument, in the week before contract signature, then incorporated into a log, which was one of the many, many documents which became part of the contract which the Chief Executive signed not knowing of the derogation.

Now, one can readily see that if, for instance, there was a suggestion that the bill payer, such as Scottish Government, should have had somebody at the contract meeting going over every dot and comma, a lawyer perhaps, they might have picked up that there was a departure from guidance and sort of went, "What?" or other such exclamation.

I wasn't sure how any of the processes that you would now hope to apply to build would have picked up that kind of late decision.

A So, the KSAR process and the NDAP process would look at adherence to guidance. So, they would ask the question around, had the guidance been adhered to, and if not, why not?

THE CHAIR: I understand that during the KSAR process. Do you think that question would be asked during the NDAP process as well?

A Well, the KSAR and the NDAP

processes overlap at FBC and-- OBC and FBC. We're looking at-- There is some duplication of questions between NDAP and KSAR so we're looking at how we can integrate that more fully.

So, what we have done with the Monklands replacement is that our colleagues who sit within Property Sustainability and Capital Planning, and our colleagues that sit within Engineering and within ARHAI are all present at all of the meetings so that we have a golden thread of understanding flowing through. So, even if it wasn't picked up at one side it would probably be picked up at the other.

THE CHAIR: Mr Connal.

MR CONNAL: Well, you've been asked questions by his Lordship about full business case because at the next stage at the new hospital, having signed the contract, was a design phase.

A Mm hmm.

Q And to put it no higher, the evidence suggests that issues over compliance with guidance, either in respect of general rooms or in respect of specialised rooms, didn't apparently feature highly on anyone's agenda, at the end of which the design was finished, the full business case was submitted, authorisation to proceed was given.

Now, I think I'm just trying to work out whether you can help us on where KSAR might have helped here, because unless it's disclosed, you know, as it doesn't appear to have been in the full business case, how does anyone know about any of these issues?

A And that's the part of-- of the KSAR-- so we are looking at how do we make sure that we've got the right and relevant information? So, the KSAR workback's will ask a number of questions of a board. They will download evidence. We will look at that evidence to see if that is compliant with legislation. We would probably ask around any derogation from the SHTMs why that was happening, or we would ask to what specification was that being built.

Q I suppose the next point-- I think you probably touched on this later-- sorry, earlier in your evidence, was that when you then go on and build it properly, I mean, one of the contractor witnesses suggested that what you should actually do at the end of design is stop before you pour any concrete and say, "Stop, pause. Are we all content that we have what we think we had and need to have" and so on and so forth, which was an interesting suggestion, but probably the next stage would then be commissioning, would it, where KSAR would come in?

A It would be. So, we would look at initial agreement, outline business

case, full business case, and then the next bit would be construction.

Q Yes.

A So, that would be the actual build itself, and we would do a KSAR during that process around construction.

Q So, one of the issues that emerged was that if the contractor produces a drawing of some part of the system, let's say ventilation for the sake of argument, somebody may come on site and check that the contractor is building what the drawing requires him to build and go, "tick" but unless somebody goes back beyond the contractor's drawing to whatever the requirement for that area was in the employer's requirements as we've been hearing, you don't know whether it's what was originally hoped for or not. Now, does KSAR help with that?

A It does, so we do walkarounds around construction and we develop quite a close relationship with the Project or Programme team within a health board and we would help to support them with doing a walkaround to ensure that what they said they were going to build, they're actually building and that it is compliant.

Q Then, I suppose if you come to commissioning, I mean, one of the topics here is, as you probably know by now, in terms of ventilation. There are two processes: the contractor commissions the ventilation, and it is intended that the client then validates it to make it does what they thought it was supposed to do, and validation wasn't done here, but would that be picked up on KSAR?

A Absolutely, yes. We wouldn't perform the validation but we would make sure that it had been done.

Q I suppose the final question, or questions, I have to you are really probably a repetition of what we've been talking about so far. You don't think it would be helpful for you to be an enforcer for the reasons you've outlined. We know there are, shall we say, big heavy sticks capable of being wielded by Scottish Government at the other end, and I think a number of parties the Inquiry might want to say, "Well, isn't the lesson from this project, if there's a lesson learned, that some kind of enforcement is necessary for boards that aren't doing what it appears they should be doing." Would you agree or not?

A I think that if NDAP and KSAR had been utilised on both of these projects, then the issues that then went on to develop, we would have had plenty of opportunities to pick up on those, and that may have given the boards the opportunity to correct those issues before occupation. I can't say that definitively because I wasn't there and KSAR and NDAP weren't being used, but that is our

collective understanding as NHS Assure.

Q So, you don't think some form of regulator with enforcement powers is necessary?

A I think that that's a discussion for yourselves and the Scottish Government around those powers. We do have a regulator.

Q My Lord, I have no further questions at the moment for this witness. I'm conscious that although a number of questions have been passed to me by other parties I may or may not have paraphrased them or changed their meaning, so I would welcome the opportunity of seeing whether other parties are going to suggest further questions for this witness.

THE CHAIR: Ms Critchley, as you may recollect our procedure allows for counsel to check with colleagues whether he has asked all the questions he should have asked, so if I can invite you to return to witness room and we should be able to get back to you in about 10 minutes.

THE WITNESS: Thank you very much.

(<u>Short break</u>)

THE CHAIR: Mr Connal, we have further questions.

MR CONNAL: A small number of further questions, my Lord, yes.

A few more questions, Ms Critchley. Mr Connal.

Thank you, my Lord. The first one is actually just to pick you up on almost the last thing you said because we-- and entirely my fault, I should have followed it up then and I didn't. We were talking about the need for an enforcer, if one can use that phrase. If you're the supporter, or the developer, or the person to assist other than KSAR, and then you said, "Well, there is a regulator", but who do you regard as the regulator?

A HIS.

Q HIS.

A Yes, Health Improvement Scotland.

THE CHAIR: Sorry, I just didn't----

A Health Improvement Scotland.

THE CHAIR: Right, thank you.

MR CONNAL: So, you would regard HIS as someone who can regulate in the way we've been discussing?

A Potentially. That may require an extension to their remit, but they are the regulator for NHS Scotland.

Q I see. Now, the other questions are probably going back to things that we did discuss, and this may assist the Inquiry in just moving forward. I was asking you questions about the KSAR process and what it might or might not have picked up, and it had been suggested, to give context to these

questions, we might usefully look at the actual KSAR document, just to give us an idea of what we're looking at, and what we've brought up on screen is Edinburgh bundle 9 at page 127, which is the workbook for KSAR for an outline business case, which I think is something along the lines of what you were telling us about. Is that right?

A Yes.

Q Right, and is that where we find the kind of material that you think KSAR will deal with?

A Yes.

Q So, we see on this page, for instance:

"The OBC KSAR will focus on how understanding of patient needs and expectations have influenced the following critical components of design, particularly in relation to IPC..."

Then, it goes on to list various things, including water and ventilation.

A That's right.

Q If we just scroll on, we find reference to guidance, so that would be picked up.

A Yes, it would.

Q And on again, 129 and that just explains who's doing the job, and 130. So, just picking-- I mean, this is a very long document and----

A It is.

Q -- I'm not going to take us through the very long document, but just to pick up an example, do we see at 1.4:

"Does the Health Board continue to demonstrate service/clinical input into design decisions based on a current and comprehensive knowledge of patient cohorts?"

A That's right.

Q That's the kind of question that you would expect to ask and get a coherent answer to?

A Yes, it is, yes.

Q Thank you. You can take that off the screen, thank you. Thank you for finding that. (To the witness) The other side of it, it, I'm afraid going back to the discussion about the follow-up to the exchanges over the reporting material. What I've been asked to put to you is this, you said that you were hopeful that things would work. Can you tell his Lordship that it will work?

A I think that's a very difficult thing to answer at this stage because we haven't actually gone through any of the processes yet. I am hopeful that it will work, and I know that everybody at GGC is also hopeful that it will work, so I think, being optimistic, I would say we will all do our best to make sure that it does.

Q Part of the reason I've been asked to ask that question, I think, is that the kind of allegations that were contained in the SBAR that we looked at

at the start of play this afternoon might not be thought best suited to encouraging a collegiate discussion. You see my point?

A I absolutely do, and I think that they may be a personal interpretation of the individual who wrote that paper and perhaps not endemic to the whole. I think that we will have to have those discussions, and that's why we've decided that we would use facilitation to support us in that.

Q I know you can only answer in respect of ARHAI. Are you aware of any similar kinds of allegations about bias and so on----

A No.

Q -- being made?

A Absolutely not.

Q Thank you.

THE CHAIR: Can I pick you up on the word, "facilitation" ? I should have maybe asked you about this before, but it didn't occur to me. By "facilitation", do you mean formally structured discussion, as opposed to just people----

A Yes.

THE CHAIR: -- chatting with each other?

A Yes, yes, formally structured and----

THE CHAIR: Right, so the relationship between Assure and GGC at the moment is one where both sides are hopeful of being able to collaborate with each other in future, but they both recognise that they have not reached that stage as at the latter part of 2025.

A That's right. I think that in some areas, we have a very, very good relationship with the IPC team within Glasgow, and I think that the nurses would say that they get on incredibly well and that they actually work in a collegiate way. So I don't want you to think that there isn't a good relationship because there is in some areas, yes.

THE CHAIR: But it's a relationship that requires to be built or built upon.

A Yes.

THE CHAIR: Through facilitated discussion. Have I got that right?

A Yes, yes.

THE CHAIR: So, right, work to be done.

A Work to be done.

THE CHAIR: Right.

MR CONNAL: I think my final question is a much more general one and I should have asked you earlier. I'm conscious that from time to time during your statement you have indicated that matters have moved on or there is an additional matter to report from the time when the witness statement was prepared, and you've given us some updates. Are there any other updates that occur to you that you ought to pass

on to us, or anything else you'd like to add?

A I don't think so. I think that we've covered quite a lot of the things that are happening as we've gone along, like the derogations work. We are doing a huge amount of work around guidance as well and we're updating both SHTM 03-01 and 04-01. We will issue new ones in probably March next year.

I think that there is a huge amount of work ongoing at the moment, and what I would say is that we are in a different landscape or environment for a build now than we were at the start of the Edinburgh and Glasgow projects.

Q Thank you. I have no further questions, my Lord.

Questioned by The Chair

THE CHAIR: A point of small detail: you're working on the principal guidance documents that we have been interested in----

A Yes.

THE CHAIR: -- 03-01 and 04-01. We've heard evidence, as recorded in the interim report, of the collaboration between Scottish authorities and English authorities.

A Yes.

THE CHAIR: If the Scottish authorities principally are sure, consider it appropriate to do so, would it be open to you to produce new drafts of SHTM 03-01 and 04-01, as it were, independent of the English texts?

A Yes.

THE CHAIR: Right.

A So, we're currently collating the review documents from also the devolved nations. We're working quite collaboratively with NHS England around our guidance but, yes, we would-- we would be happy to publish Scottish guidance, which we then would have worked on with the devolved nations, and they may well adopt that guidance following our publication.

THE CHAIR: You wouldn't feel vetoed----

A No.

THE CHAIR: -- if there was a different view taken south of the border?

A No.

THE CHAIR: Right. Thank you. Well, that is the end of your evidence, Ms Critchley, and that means you're free to go. But before you do that, can I thank you for your attendance again for an inquiry hearing and the obvious research and preparation that has gone into allowing you to give that evidence. But thank you very much, and you're free to go.

THE WITNESS: Thank you.

(The witness withdrew)

THE CHAIR: Now, as I understand it, that's our evidence for today, and we will resume with Mr Mackintosh tomorrow.

MR CONNAL: Indeed, my Lord.

THE CHAIR: The witnesses are Dr Davidson and----

MR CONNAL: Dr Davidson and Professor Gardner.

THE CHAIR: And Professor Gardner. Very well. Can I wish you a good afternoon, and we shall see each other, all being well, tomorrow?

(Session ends)

(3.19 p.m.)