SCOTTISH HOSPITALS INQUIRY

Witness Statement

of

Alan Morrison

In response to a Rule 8 Request dated 10 February 2022

11 April 2022

Professional Background

1. My name is Alan Morrison. My date of birth is [redacted]. I am 51 years old.

2. I am a civil servant employed by the Scottish Government as the Interim Deputy Director of Health Infrastructure. I have held this role since March 2020. My background is in accountancy and I have a professional accountancy qualification from the Chartered Institute of Public Finance and Accountancy which I obtained in 1998.

3. I have been employed by the Scottish Government since April 2003. During that time I have worked in the Health Finance Directorate in a number of different roles as a qualified finance professional. Between January 2015 and March 2020 I was the Capital Accounting and Policy Manager for Health Infrastructure. While my job title changed between January 2015 and the present day the duties have remained broadly the same since January 2015, the main duties of which are:-

    - Developing and delivering the Capital Investment Strategy for the Health Portfolio, ensuring that it aligns with the infrastructure priorities of the wider Scottish Government, including delivering sustainable economic growth and delivering a lower carbon economy.

- Managing the portfolio's capital budget of ~£0.5 billion, ensuring that a breakeven position is delivered each year, that the expenditure supports the portfolio's strategic priorities and that value for money is delivered.

- Chairing (from December 2015) the Scottish Government Health and Social Care ("SGHSC") Capital Investment Group ("CIG") which oversees the review and scrutiny of all business cases submitted to SGHSC, as well as being the lead official for the national infrastructure board.

- Interpreting HM Treasury and Scottish Government capital accounting and budgeting guidance and subsequent provision of advice to NHSScotland finance professionals through working groups and written guidance.

- Leading the development of strategic advice to Ministers on the options and opportunities for prioritising, financing and delivering infrastructure investment, including how it can help enable service reform and support clinical priorities.

- Managing and developing the capital accounting and policy framework for NHSScotland that ensures compliance with HM Treasury and Scottish Government accounting, budgeting and legislative requirements. This includes effective management of the capital investment programme and of property transactions, as well as performance management.

- Managing assurance processes in respect of major capital programmes of work by health boards: as well as engagement with internal stakeholders, one of my key responsibilities in this regard is to develop and maintain links with a range of external stakeholders including other national groups, applying specialist knowledge and skills to review, analyse and manage risks.

4. In January 2021, I assumed responsibility for pandemic Personal Protective Equipment ("PPE"). Prior to the pandemic, there was no need for a PPE team, therefore this was a new area of responsibility to manage.

5. I have been involved with the Royal Hospital for Children and Young People ("RHCYP") and Department of Clinical Neurosciences ("DCN") project (together "the Project") since starting my role as Capital Accounting and Policy Manager and subsequently as Interim Deputy Director for Health Infrastructure and Investment. None of the jobs I held prior to January 2015 had any involvement with the Project.

Overview

6. In this statement I will address the undernoted themes:-

    a. The Scottish Government Health and Social Care Directorates
    b. The Scottish Public Finance Manual and The Scottish Capital Investment Manual
    c. SGHSC Capital Investment Group
    d. SGHSC Capital Investment Group – Business Case Review Process
    e. Health Facilities Scotland
    f. NHSScotland Assure
    g. Answers to Rule 8 request dated 10 February 2022

The Scottish Government Health and Social Care Directorates

7. SGHSC is a group of Scottish Government Directorates responsible for Health and Social Care in Scotland. There are 13 directorates in the group and each directorate assumes responsibility for a different function of the NHS' delivery of health and social care in Scotland. The current directorates are:-

    - Chief Medical Officer;
    - Chief Nursing Officer;
    - COVID Public Health Directorate;
    - Digital Health and Care Directorate;
    - Health Finance, Corporate Governance and Value Directorate;
    - Health Performance and Delivery Directorate;
    - Health Workforce Directorate;

- Healthcare Quality and Improvement Directorate;
- Mental Health and Social Care Directorate;
- Population Health Directorate;
- Primary Care Directorate;
- Test and Protect; and
- Vaccine Strategy and Policy.

8. I am the Interim Deputy Director for Health Infrastructure. Health Infrastructure falls within the Directorate for Health Finance, Corporate Governance and Value. The director of the Health Finance, Corporate Governance and Value Directorate is Richard McCallum.

9. Since the beginning of my tenure in my current role, my team has been responsible for Health Infrastructure and Investment. Since the beginning of the pandemic, my team has also been responsible for PPE. The division is responsible for managing the overall NHSScotland capital budget, the co-ordination and management of the NHSScotland Infrastructure Investment Programme and for policy co-ordination in relation to pandemic personal protective equipment.

10. As I explain more fully below, all relevant business cases in relation to healthcare capital projects are considered by my team and supporting staff from across SGHSC. Health boards are reliant upon funding approval from the Scottish Government. If the Scottish Government does not approve the business case then the facility under contemplation cannot proceed.

<u>The Scottish Public Finance Manual and The Scottish Capital Investment Manual</u>

11. The Scottish Public Finance Manual ("SPFM") is issued by the Scottish Ministers to provide guidance to the Scottish Government and other relevant bodies on the proper handling and reporting of public funds.

12. The Scottish Ministers have also issued related guidance that is sector specific. The Scottish Capital Investment Manual ("SCIM") (Bundle 3, volume 2, document 33, p.120)

provides guidance, in an NHS context, on the processes and techniques to be applied in the development of all infrastructure and investment programmes and projects within NHSScotland. The guidance applies to the cyclical process of project development from inception (at the service planning stage) to post project evaluation of service benefits realised. The guidance not only covers issues around investment appraisal, financial (capital and revenue) affordability and procurement, but also the project management and governance arrangements required to support the development of such programmes and projects.

13. The principles set out in SCIM are applicable to all NHSScotland Bodies in relation to the development of all infrastructure and investment schemes, regardless of their size or complexity, and are designed to provide an audit trial and assurances that appropriate steps have been followed in the investment decision making process.

14. All health infrastructure business cases submitted for consideration will be assessed against the guidance contained within the SPFM and SCIM. If a business case is non-compliant it will not be approved.

SGHSC Capital Investment Group

15. The SGHSC Capital Investment Group ("CIG") is responsible for monitoring[1] the delivery of major capital investment projects developed by health boards (regardless of the ultimate funding route adopted by the procuring organisation) and recommending whether or not approval should be given by the Director General concerned. CIG is constituted by representatives from across SGHSC – I have noted a list of the current SGHSC Directorates at paragraph 7 above.

[1] "Monitoring" via the business case review process described at paragraphs 22-42 below as well as by consideration of post project evaluation. Post project evaluation is the process of assessing the impact of a project after it has come to an end. Two stages are defined; namely Project Monitoring and Service Benefits Evaluation. Project Monitoring will cover the technical aspects of the planning, implementation and completion phases of a project (i.e. generally, the construction phase), and the Service Benefits Evaluation will cover the impact of the project on service change and benefits realisation – the project's benefits register and realisation plan will form a significant part of this latter assessment.

16. I have been the chair of CIG since December 2015 and have been a member of it since November 2015.

17. The Chair of CIG has delegated authority to approve projects with a capital cost of up to £5 million. For projects between £5 million and £10 million, CIG will, following the successful consideration of a Business Case, make a recommendation for approval to SGHSC Director of Health Finance who has delegated authority to approve. Where a scheme has a capital cost in excess of £10 million CIG will make a recommendation to the Director General for Health and Social Care (the "Director General"). The delegated authority limits of CIG are published on the Scottish Government's website at https://www.pcpd.scot.nhs.uk/Capital/Approval.htm (under tab - "Delegation within SGHSC"). (Bundle 3, volume 3, document 79, p.1,312).

18. CIG receives advice and support on planning, procurement, construction and facilities management issues from NHS National Services for Scotland ("NHS NSS") and the Scottish Futures Trust. CIG will also obtain advice from relevant clinical and policy colleagues where appropriate.

19. By approving the business cases submitted to CIG, the Director General gives health boards the assurance of SGHSC support for the strategic justification for progressing capital schemes whilst sending a clear indication to the private sector that the projects are supported by the Scottish Government.

20. CIG also plays a vital role in providing the necessary assurances to both Scottish Ministers and SGHSC Management Board that proposals are robust, affordable and deliverable.

21. CIG also acts as a forum for the development, promotion and distribution of best practice and guidance within capital planning and development whilst providing SGHSC with an overview of the strategic direction of NHSScotland.

SGHSC Capital Investment Group – Business Case Review Process

22. I understand that the Inquiry, at this time, is not focussed on the detail of the particular business case reviews undertaken for the Project, so I describe below the general process by which a project is approved by CIG in order to provide the Inquiry with a broad understanding the different roles and responsibilities applicable to the parties involved in a business case review.

23. The Inquiry will, in due course, come to consider the journey of the Project's business case and the Scottish Government will be happy to provide evidence in relation thereto at a time that is considered appropriate by the Inquiry.

24. It is for the health board to develop the project that it wishes to deliver. SCIM makes clear that under no circumstances should responsibility for the direction and lead production of the business case be outsourced to external consultants.

25. The role of the Scottish Government is to consider whether the business case meets the requirements of SPFM and SCIM and to either approve or reject the proposal. Not all projects require the approval of the Scottish Government. When a health board wants to deliver a significant capital project (usually the upgrading of an older facility or the development of a new facility) they must first consider whether that is something that can be dealt with under the health board's own delegated authority or whether it requires reference to CIG. The determinative factor is the value of the project's capital expenditure. Annex C to the Chief Executive's Letter dated 19 August 2010 contains the delegated authority limits that were applicable to the Project (Bundle 4, document 11, p.146). The current limits are contained within a director's letter (from the Director of the Health Finance, Corporate Governance and Value Directorate) dated 12 September 2019 (Bundle 3, volume3, document 79, p.1,312).

26. Having identified the project as one falling outwith the delegated authority limit it is incumbent upon the health board to seek the Scottish Government's approval (via CIG). CIG encourages the early engagement of the health board and it is common for there to be several meetings between CIG and the health board prior to and during submission of the documents I explain below, namely (as named in SCIM) the "Initial Agreement" (so named but in reality a proposal), "Outline Business Case" and "Full Business Case" (and

any addendum thereto). The procedure for submission and content of these documents is regulated by SCIM.

27. Having identified the parameters of the project the health board should submit an Initial Agreement to CIG for review and approval. I would expect the Initial Agreement to set out what the health board's proposal is about. In particular it should explain the current arrangements by which the health board is providing its services and why there is a need for change. To comply with the principles outlined in SCIM, I would expect the Initial Agreement to identify the proposed strategic/service solution designed to meet the health board's need. Finally, I would expect the Initial Agreement to consider whether the health board is ready to proceed with its proposal, taking into consideration the commercial, financial and management needs associated with the proposal.

28. Once submitted, the initial agreement will be circulated amongst the members of CIG and, thereafter, considered at a meeting of CIG. CIG will either reject the initial agreement or recommend that the Director General approves it. CIG's consideration is guided by the advice contained in SPFM and SCIM, however, it employs a subjective approach to each assessment. If the initial agreement is rejected the health board will be advised why. As with review at all stages, a rejection usually prompts the health board to revise and resubmit its proposal.

29. If the Initial Agreement is approved, the health board submits an outline business case to CIG for consideration. To comply with the principles outlined in SCIM, the Outline Business Case will identify the preferred option for implementing the strategic/service solution approved at Initial Agreement stage. It will demonstrate that the preferred option will deliver the necessary service change, optimise value for money, and be affordable. It will also set out the supporting commercial and management arrangements to be put in place to successfully implement that option. A developer can only move on to procurement (by whatever means it considers appropriate) once it has received approval of its outline business case from the Scottish Government.

30. Finally, the health board submits its Full Business Case to CIG for consideration. The full business case will set out the agreed commercial arrangements for the project whilst also confirming that it remains value for money, is affordable, and that the organisation is ready to proceed towards implementation of that option. The Full Business Case will

be developed by the health board (essentially by revising and expanding upon the Outline Business Case) within the final procurement phase of the project and record the detailed assessment and/or negotiations with potential service providers/ suppliers prior to the formal signing of contracts but does not include the actual procurement documentation (such as an environmental matrix which forms part of the invitation to tender) utilised by the health board.

31. I would expect all issues to be resolved and agreed by the health board prior to it submitting the final business case to CIG. CIG needs to know what it is recommending to the Director General for approval. A health board may also submit an addendum to its final business case where it requires further approval for matters not contained in (or which would derogate from) the full business case.

32. The business case review process is intended to be scalable and flexible to ensure that the effort required in preparing the relevant documents is appropriate. The level of detail required will be dependent upon the scale, risk and nature of the investment proposal. It should, however, meet the expectations and information needs of CIG. The health board can consult CIG for further advice on these expectations.

33. All business cases are circulated to the members of CIG to consider not only the content of the business case but also the deliverability of the project. In that respect, CIG will be interested in the health board's Management Case, to look at whether the Board have a suitably resourced and experienced project team in place to deliver the project and also whether the health board's governance arrangements are appropriate. CIG also examines the extent to which the project is aligned with national, regional and local priorities (the last as articulated in Local Delivery Plans and associated Property and Asset Management Strategies). For example, I would look for health boards to mention the Quality Strategy relevant to its area or explain how more services could be delivered at home or in a community setting (which is a long established policy objective of the Scottish Government) or, where possible, link to the National Planning Framework, which is a long term plan for Scotland that sets out where development and infrastructure is needed. Each CIG member will focus on their specialist area of the business case, for example financial or clinical aspects, and submit their comments to Capital and Facilities in advance of the meeting. The CIG member can, however, comment on other aspects of the business case if he/she considers it appropriate. My own area of focus is finance.

34. Policy Leads from the Health Finance and Infrastructure Division will collate the comments, seeking further clarification from the health board if necessary, before CIG meet to take a collective decision about the project. CIG members, acting as a group (in consensus), decide whether or not to make the recommendation for approval to the Director General (or Director of Finance if delegated or due to particular circumstances, e.g. the Director General being on leave or otherwise unavailable). CIG may also seek the appropriate clarification from the health board on issues to be resolved prior to making any recommendation for approval. If CIG concludes that it cannot recommend approval at any given point, the health board will be advised of that and it will then be for the health board to decide whether to work further on the proposal and bring a further iteration of the proposal to CIG for further consideration.

35. The Health Finance and Infrastructure team retains some oversight of the project until it is completed. This will involve discussions on timeline and affordability and any challenges the project may be experiencing. Usually that involves relevant officials from the Scottish Government meeting with members of the project team and/or sitting on project boards (set up for delivery of the project) once business plans are approved.

36. CIG carefully scrutinises all stages of the business case review process. CIG is conscious to ensure that the business case is fully compliant with the SPFM and SCIM guidance and requirements. The review is detailed but undertaken at a reasonably high level. By that, I mean that CIG is concerned to note that all relevant requirements have been met (such as technical specifications) but CIG recognises that, ultimately, it is the health board who are delivering the project. Thus, if the health board undertakes that a certain element of its design is compliant with the relevant technical memorandum then CIG does not check that the actual design is, as a matter of fact, compliant.

37. If the health board did seek to derogate from the standards and guidance contained within SPFM, SCIM or elsewhere it would be for the board to identify the derogation and seek approval from CIG. In my experience, no derogations have in fact been brought to my attention, though I am aware that a derogation was (before my involvement with CIG) sought in relation to the policy as to the proportion of single beds in hospitals (in relation to the Project).

38. Projects involving private finance require the approval and commitment of private finance partners before CIG will issue a recommendation for approval of the full business case. It is the health board's responsibility to satisfy CIG of this. The private finance partners' commitment is often not reached until "financial close". In a Public Private Partnership ("PPP") project, financial close is usually the stage at which project agreements between the health board and project co (the consortium who is delivering the project) have been concluded. Until this stage is reached, or it is clear that this stage will be reached, CIG cannot be certain that the private finance required to deliver the development has been committed to it.

39. Accordingly, in a PPP project, such as the Project, CIG generally recommends approval of the final business case in two stages. Firstly, CIG satisfies itself that the business case can be approved but for the occurrence of financial close (and other minor matters) (stage one). At this stage, CIG may make a formal recommendation and a letter may be issued to the health board authorising the health board to proceed to financial close, however, this does not happen in all cases. Thereafter, CIG monitors the project as it approaches financial close (the health board is obliged to keep CIG up to date). Once CIG is satisfied that financial close will be reached then it will make a recommendation to approve the full business case (stage two).

40. It is common for business cases (particularly at the early stages) to be rejected by CIG. I would estimate that this happens in approximately 50% of all cases. The most common reason for rejection is that the proposed improvement in services has not been effectively articulated and there are too many unanswered questions. Unanswered questions could include matters such as whether the health board had consulted with regional partners on the possibility of delivering a regional service; whether there is adequate workforce available to staff the new facility; whether the revenue costs affordable; or whether the health board has maximised the use of digital options etc.

41. It is also common for there to be an open dialogue between the health board and CIG as its business case progresses – in fact, this is encouraged. The process is designed to deliver affordable and effective solutions to health care needs across Scotland. It is in all parties' interests to see that that end goal is achieved.

42. Finally, the whole process from inception at health board level to approval of the full business case by Scottish Government takes many years – often more than a decade.

Health Facilities Scotland

43. NHS NSS provides services and advice to the NHS and public sector. NHS NSS is a non-departmental public body established under s10 of the National Health Service (Scotland) Act 1978. NHS NSS is independent of, but accountable to, the Scottish Government. NHS NSS provides a wide range of services ranging from legal support (the Central Legal Office) to the facilitation of blood transfusion services (the Scottish National Blood Transfusion Service).

44. Health Facilities Scotland ("HFS") is the division of NHS NSS which has particular responsibility for the provision of operational advice and guidance to NHSScotland bodies on a range of healthcare facilities topics. HFS is responsible for establishing professional and technical standards and best practices. In particular, HFS is responsible for the publication of the Scottish Health Technical Memoranda ("SHTM").

45. SHTM are directed at those providing healthcare services. The memoranda cover a range of technical practice areas and provide comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare. SHTM apply to new and existing healthcare sites and are for use at various stages during the lifecycle of a facility.

46. The Scottish Government is not responsible for the publication of SHTM. My role requires me to be aware of the importance and general content of SHTM. However, and as I explained at paragraph 45 above, the technical application of SHTM is a matter for those providing healthcare services and I am not familiar with their technical content in any great detail.

47. CIG expects a business case presented to it to be compliant with the relevant SHTMs. It is for the health board to guarantee such compliance. If the health board seeks to derogate from SHTM it should make this clear in its business case and make the appropriate request to the relevant SGHSC, however this does not happen very often.

The content of an "appropriate request" will depend upon the standard being derogated from and the reasons therefore. Where derogation is sought from a "clinical" standard I would expect the health board to include a "clinical" justification for the derogation within its request.

NHSScotland Assure

48. In September 2019, the Scottish Government published the Programme for Government [Source: https://www.gov.scot/publications/protecting-scotlands-future-governments-programme-scotland-2019-20/] which included the following ambition '*To ensure patient safety we will create a new national body to strengthen infection prevention and control, including in the built environment. The body will have oversight for the design, construction and maintenance of major infrastructure developments within the NHS and also play a crucial policy and guidance role regarding incidents and outbreaks across health and social care'*. This addition to the Programme for Government arose from the Scottish Government's consideration of the issues and incidents identified in the built environment of the new hospitals at QEUH and RHCYP (throughout 2019).

49. Consequently, NHS NSS received a commission from the Scottish Government to support the creation of Quality in the Healthcare Built Environment – this later became known as NHSScotland Assure ("NHSSA"). The service was designed to improve the management of risk in the built environment across Scotland, providing greater confidence to stakeholders. The model was enabled by establishing robust relationships across the system, having joint accountability alongside health boards and will, in due course, provide a structured forum that will enable construction professionals and clinical colleagues to work in an integrated manner to ensure that the healthcare built environment is safe, fit for purpose, cost effective and capable of delivering sustainable services over the long term.

50. NHSSA was established in June 2021 (though an Interim Review Service had been running since early 2020). Like HFS, NHSSA is a division of NHS NSS. When NHSSA was launched, it was described by the Scottish Government as bringing together experts *"to improve quality and support the design, construction and maintenance of major healthcare developments. This world first interdisciplinary team will include*

microbiologists, infection prevention and control nurses, architects, planners, and engineers. Commissioned by the Scottish Government and established by NHS National Services Scotland, the service will work with Health Boards to ensure healthcare buildings are designed with infection prevention and control practice in mind, protecting patients and improving safety." [Source: https://www.gov.scot/news/nhs-scotland-assure/]

51. NHSSA seeks to align compliance with all relevant guidance and helps health boards demonstrate this at key review stages of a facility's build process. NHSSA focusses on new builds and major refurbishments within the healthcare estate. NHSSA will also consider projects that are identified as complex due to the needs of patients using the facilities.

52. At paragraphs 22 to 42 above I explained the business case review process undertaken by CIG. NHSSA work with the health board during the preparation and presentation of its business case. In particular, NHSSA will review business case proposals to ensure compliance with relevant technical standards and guidance. From 1 June 2021, all health board projects that require review and approval from CIG, will need to engage with NHSSA to undertake key stage assurance reviews ("KSAR"). Approval from CIG will only follow once the KSAR has been satisfactorily completed. The KSARs have been designed to provide assurance to the Scottish Government that guidance, such as SHTMs, has been followed. The Scottish Government may also commission NHSSA to undertake reviews on other healthcare built environment projects.

53. NHSSA's engagement does not change accountability for the projects: health boards remain accountable for their delivery and NHSSA will be accountable for the services it provides that support delivery of the health board's projects.

54. NHSSA will also work closely with health boards to identify where a KSAR may be required for projects under their Delegated Authority, utilising a triage system to assess risk and complexity of projects.

55. The KSAR focuses on key topics, specifically – IPC (infection control), water, ventilation, electrical, plumbing, medical gases installations and fire. The aim is to ensure

that projects are designed, installed and functioning from initial commissioning of a new facility and throughout its lifetime. Health boards are required to have appropriate governance in place at all stages of the construction procurement journey.

56. Each health board will be fully responsible for the delivery of all projects, and its own internal process and resources for carrying out internal reviews and audits of its activities. The KSAR is seen as a complementary independent review, and not as a replacement for the responsibilities of the health board.

Answers to Rule 8 request dated 10 February 2022

57. I have been asked to provide the Inquiry with certain evidence relating to my involvement in the design, planning and construction of the Project, in particular, in relation to the application of SHTM and other relevant guidance and the effect of Chief Executive Letters ("CELs"). The request for information was made by the Inquiry in a Rule 8 Request dated 10 February 2022 ("the Request"). The subheadings in bold below correspond with the subheadings contained in the Request.

58. I have carefully reviewed the section of the Request headed "Subject Matter", reproduced at the end of this statement (Appendix 1). I agree that the contents of this section of the Request, including those facts taken from the SHTMs, is accurate.

59. I have considered whether there is additional information for the Inquiry to understand about the respective roles of HFS, the Scottish Ministers and health boards in ensuring that ventilation in healthcare premises is compliant with all applicable standards. As I have explained at paragraph 53 above, health boards are responsible for ventilation (and all critical systems) across their healthcare estate. HFS provide guidance (and may provide support) to the health board but compliance with that guidance is a matter for the health board.

60. As I explained at paragraphs 43 to 47 I am familiar with HFS' guidance, including SHTMs, however, my current role does not require me to consult this guidance on a regular basis. Consequently, I am aware of their purpose and function (as I describe above) but not their technical content. I am also familiar with the class of document known as CELs. As I explain more fully below, these are letters issued by the Chief

Executive of NHSScotland to the Chief Executives of the health boards across Scotland (and other relevant persons). Since 2014, similar letters have been issued by SGHSC Directors, rather than the Chief Executive. I have been involved in drafting and issuing some of these letters, such as DL[2] 2019 (5) which updated NHS Boards' capital delegated limits (see paragraph 25 above), (Bundle 3, volume 3, document 79, p.1, 312).

SHTMs

61. As I explained at paragraph 44, HFS is responsible for preparing and publishing SHTMs. HFS approves draft SHTMs and authorise their publication. SHTMs are usually, drafted, revised and published after review by a relevant governance group (with expertise in the relevant subject matter). HFS is responsible for this process.

62. The aim of SHTMs is to ensure that everyone concerned with the management, design, procurement and use of healthcare facilities, understands the requirements of the specialist, critical building and engineering technology involved. SHTMs are one piece of guidance from a suite of technical guidance provided to healthcare providers (such as Scottish Health Facilities, Planning, Technical and Building Notes). HFS is best placed to advise the Inquiry as to the interrelationship between SHTMs and other guidance. I am not required to use Scottish Health Facilities, Planning, Technical and Building Notes in my role.

63. SHTM guidance is directed at estates and facilities professionals working to deliver healthcare services in Scotland, in particular, those that work in NHSScotland. HFS communicates SHTMs (and other guidance) via the NHS Strategic Facilities Group ("SFG") and the various technical sub-groups that report directly to it such as the Scottish Engineering Technology Advisory Group and Scottish Property Advisory Group. I have a general understanding of these groups, however, HFS would be would be best placed to provide the overview of the governance structure and various groups that report directly to SFG.

[2] "DL" is the acronym used to denote "Directors Letter" – a letter issued by a SGHSC Director.

64. HFS is a division of NHS NSS (a non-departmental public body). NHS NSS are accountable to the Scottish Ministers. NHS NSS' have a statutory mandate (per The National Health Service (Functions of the Common Services Agency) (Scotland) Order 1974) to provide national strategic support services and expert advice to Scotland's health sector whilst maximising health impacts and cost savings.

65. SHTM is guidance as to best practice. The Inquiry has asked whether compliance with SHTMs is mandatory. As I explained at paragraph 47 CIG expects business cases submitted to it for review to be compliant with SHTM and if they are not, expects health boards to seek approval for any derogations. In that regard, CIG would expect the health board to take a risk managed approach that involves relevant stakeholders, to be followed before there is any departure from SHTMs. The newly followed KSAR process (undertaken by NHSSA), examines what derogations have been requested and reviews the proposed local governance arrangements for derogations.

66. It is difficult to comment upon what will happen where a health board fails to comply with SHTM because the potential range of non-compliance is wide. Where there was egregious non-compliance (for example a disregard of fire safety standards) SGHSC are likely to intervene and take steps to remove a project board. Such a situation has never arisen and it is almost inconceivable that a health board would behave this way. SGHSC would expect less serious instances of non-compliance to be managed by health boards. HFS and the health boards would be best placed to comment on this.

67. As I explained a paragraph 47 it is possible to derogate from SHTMs. It will be for each health board to determine its own processes in so far as derogation is concerned and the Scottish Government would rarely get involved in this process. However, I would expect there to be an audit trail that explains what has been requested, why it has been requested, what decision has been taken and why. This process should be transparent and open and be flexible enough to deal proportionately with each request. For example, a relatively minor request (made during the construction phase of a project) could perhaps be dealt with by the project manager or project director; a more significant request would perhaps go to the Project Governance Board or even the Scottish Government. The only example of derogation from guidance (not an SHTM), of which I am aware, that involved the Scottish Government was the derogation from the single room policy (as contained in the

CEL dated 2 July 2010) that occurred during the business case review of the Project. (Bundle 4, document 10, p.144.

68. I understand the Inquiry is interested in what those who are required to consider and apply SHTM should do when the guidance does not cover a particular situation, is ambiguous or has been superseded by legislation or best practice. It is for health boards to consider how to apply SHTMs; the Scottish Government would not get involved in decisions concerning their application. However, the Scottish Government, and in particular CIG, is aware that during the design and build of a new hospital (which will take many years) it is inevitable that guidance and legislation will change over that time. Where it is possible to accommodate new best practice guidance with minimal disruption, CIG would expect a health board to implement these changes. If adoption of new guidance would lead to additional cost or create a delay, we would expect the project team responsible for delivery to follow the approach outlined at paragraph 47. An exception to this practice would be if there was a change in a Board's statutory duty e.g. fire safety guidance, then the Board would need to comply with the change.

69. NHS Lothian and HFS are best placed to advise on the SHTMs and other documents relevant to ventilation systems at the Project.

70. HFS would also be best placed to advise on the reason for the import of "disclaimers" to SHTM.

71. I am aware that when HFS is drafting SHTM they consult with the other administrations across the UK. I understand that HTM 03-01 is the guidance applicable in England and Wales that is equivalent to SHTM 03-01, however, HFS would be best placed to comment thereon. I am also aware that the National Heating & Ventilation Advisory Group reports to the Scottish Engineering Technology Advisory Group, which in turn reports to the SFG (as discussed at paragraph 63). However, HFS would be best placed to comment on the work of these advisory groups and the contribution made to specific reviews.

Chief Executive Letters

72. CELs are letters sent from the Chief Executive of NHSScotland and Director General of Health and Social Care ("the Director General"). As I explained at paragraph 60, since 2014 all letters issued from SGHSC have been issued by Directors rather than the Director General; these are known as Directors' Letters ("DLs"). This reflected the view of the then Director General, who thought CELs would only be used for the most important issues.

73. The Director General provides strategic direction to the NHS in Scotland and drives performance, efficiency, value for money and the delivery of sustainable safe, effective and person-centred services as well as a general responsibility for maintaining a high standard of care for the people of Scotland and for providing support to Scotland's health and social care professionals. The Director General, amongst others, discharges the Scottish Government's functions under ss1 and 1A of the NHS (Scotland) Act 1978. The statutory basis of a CEL will depend on the context of each letter. Some of the guidance issued to health boards may be considered as administrative instructions, not falling within section 2(5) of the 1978 Act. Alternatively, the wording of the guidance may be framed as imposing obligatory requirements under the statutory powers and direction of the Cabinet Secretary for Health and Social Care.

74. CELs are issued either (a) to impose mandatory requirements on NHS Boards or (b) on an advisory or "Best Practice" basis. For example, DL (2019) 23 confirms mandatory HCAI and AMR policy requirements but some elements of the guidance was given on a best practice basis (Bundle 3, volume 3, document 80, p.1,314).

75. In my experience, CELs and DLs are complied with by those to whom they are directed. If a health board refused to comply with the terms of a CEL then the Scottish Ministers may make a direction, obliging compliance, in accordance with s2(5) of NHS (Scotland) Act 1978. The consequences of non-compliance will depend on the contents of each letter and on what basis it has been issued. Guidance is not normally legally enforceable.

76. If a health board sought to derogate from the terms of a CEL when submitting a business case for review to CIG, I would expect that derogation to have been justified and approved by the relevant parties within SGHSC. My comments at paragraph 47 in relation to derogation from SHTM apply equally to CEL.

77. A failure by a health board to comply with the terms of a CEL may result in ministerial direction, however, I am unaware of this ever happening. Derogations from CELs are rare. The only derogation of which I am aware is the derogation from the CEL relating to single room policy during the business case review for the Project. I am not aware of the detail of what happened as this pre-dated my involvement with the Project. There is not a specific process for derogation, if a health board thought an issue was worthy of a derogation, then either their Chief Executive or an Executive Director of the Board would discuss the matter with a senior Scottish Government colleague (relevant to the subject matter of the derogation) – requests would be considered on a case by case basis.

78. CELs are drafted by the relevant policy leads at the Scottish Government. The letters cover a range of subjects, thus the drafting is department specific. Prior to being issued the relevant policy lead would agree the content of the CEL and obtain the support of the relevant SGHSC Director. Once drafted and approved by the relevant Director, the letter would be sent to the Director General's office for approval. All CELs are issued from the Director General's mailbox.

79. CELs are directed to relevant persons within health boards. Who is relevant depends on the subject matter of the letter. Typically, letters would be issued to NHS Board Chief Executives and NHS Board Chairs, they would also be copied to the Director at each Health Board who leads on the subject contained in the letter. For example, if the letter was about healthcare facilities, then it would go to Directors of Estates and Facilities, Finance issues would go to Directors of Finance etc.

80. I understand that the Inquiry is interested in the extent to which those responsible for the design planning, construction and operation of hospitals have discretion to depart from CELs. CELs cover a wide range of topics, however, with the exception of the single room policy, I am not aware of any CEL that covered any part of the design, planning, construction and operation of a new hospital. Accordingly, I cannot comment on whether or not it is advisable or common for such departure to take place. Likewise, I cannot comment on what the same parties are to do if a CEL does not cover a particular situation or is ambiguous.

81. As I explained at paragraph 78, the drafting of CEL and DL is department specific. My department has not drafted any CELs or DLs in relation to ventilation systems. The Scottish Government can provide the Inquiry with a list of any relevant CELs and/or DLs drafted by other SGHSC directorates if that would be of assistance to the Inquiry's ongoing investigations.

82. I believe that the facts stated in this witness statement are true. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.

APPENDIX 1

Subject Matter

The Inquiry has identified certain guidance and Scottish Government correspondence as relevant to its terms of reference. These include Scottish Health Technical Memorandum 03-01 – Ventilation for Healthcare Premises Part A – Design and Validation ("SHTM 03-01 Part A") and so-called "Chief Executive letters" including CEL 48 (November 2008) and CEL 27 (July 2010) on single-room accommodation. The Inquiry is keen to understand the status and purpose of such documents insofar as they are relevant to its Terms of Reference.

Versions

1. The Inquiry has version 2 of SHTM 03-01 Part A dated February 2014. It does not presently have version 1. It understands that SHTM 03-01 version 1 was preceded by SHTM 2025. It is not clear to the Inquiry at present which version(s) applied to the RHCYP/DCN project or over what time periods.

2. SHTM 03-01 v.2 explains that it is part of a series of engineering-specific guidance in nine parts. The series is said to include SHTM 00: Policies and Principles, which is said to be applicable to all SHTMs in the series. SHTM 00 version 2.1, dating from February 2013, is available to the Inquiry. It has the fuller title SHTM 00: Best Practice Guidance for Healthcare Engineering: Policies and Principles. The Inquiry does not presently have earlier versions.

3. The questions which follow are based upon the versions of SHTM 00 and SHTM 03-01 which are presently available to the Inquiry, on the assumption that insofar as material to those questions those versions are substantially the same as the versions which applied to the RHCYP/DCN project. If that assumption is not correct, please notify the Inquiry team at the earliest opportunity and clearly reference which versions you refer to in your statement. We would, in any event, welcome confirmation of the version(s) of the guidance which applied to the RHCYP/DCN project, over which time periods. If they are available to you, please provide copies of all relevant versions of the guidance.

Health Facilities Scotland

1. The versions of both SHTM 03-01 and SHTM 00 presently available to the Inquiry bear to have been published by Health Facilities Scotland ("HFS").

2. The Inquiry understands that HFS is part of the Procurement, Commissioning and Facilities division of NHS National Services Scotland ("NHS NSS"); that NHS NSS is the name given to the body established in statute as the Common Services Agency; and that the statutory basis for NHS NSS is currently section 10 of the National Health Service (Scotland) Act 1978 and the National Health Service (Functions of the Common Services Agency) (Scotland) Order 2008.

3. Under section 10(7) of the 1978 Act, NHS NSS is required to act "*subject to, and in accordance with"* directions given by the Scottish Ministers. Under section 10(3), the Scottish Ministers may delegate to NHS NSS such of their functions relating to the health service as they consider appropriate. (The 1978 Act refers to the Secretary of State but, following devolution, such references are to be read as meaning the Scottish Ministers: section 53 of the Scotland Act 1998.)

4. The functions delegated to NHS NSS under the 2008 Order include the provision of "*information, advice and management services in support of the functions of Scottish Ministers, HIS, Health Boards and Special Health Boards"* (2008 Order, article 2(f)).

5. The Inquiry understands, based on information from NHS NSS, that HFS "*provides operational expertise and guidance on subjects related to healthcare facilities"* and that it "*establishes professional and technical standards and best practice procedures"* (source: NHS National Services Scotland Overview, paper to Inquiry).

6. NHS NSS has explained to the Inquiry that HFS has formed part of NHS NSS since 2006, when the Property and Environment Forum and its executive body, the Property and Environment Forum Executive ("PEFEX"), became part of NHS NSS and were renamed HFS.

7. The Prefaces to SHTM 03-01 and SHTM 00 provide an introduction to SHTMs (pages 7 and 5 respectively). These state that SHTMs give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare. They explain that the focus of SHTM guidance remains on healthcare-specific elements of standards, policies and up-to-date established best practice. They refer to healthcare providers having a duty of care to ensure that appropriate engineering governance arrangements are in place and are managed effectively. They state that the SHTM series "*provides best practice engineering standards and policy to enable management of this duty of care"*. They explain that the suite is not intended to repeat unnecessarily international or European standards, industry standards or UK Government legislation, but that where appropriate those would be referenced. They state that SHTM guidance was the main source of specific healthcare-related guidance for estates and facilities professionals. They state that the suite provided access to guidance which was more streamlined and accessible; encapsulated the latest standards and best practice in healthcare engineering; and provided a structured reference for healthcare engineering.

8. The Executive Summary to SHTM 00 states that it is provided as a comprehensive guide to all issues relating to the management of engineering and technical service provision wherever NHS patients are treated. It states that, whilst it is not intended to cover every possible scenario, its standards and principles may be appropriate to follow in all locations where healthcare is provided. It states that the aim of SHTM 00 was to ensure that everyone concerned with the management, design, procurement and use of a healthcare facility understood the requirements of the specialist, critical building and engineering technology involved. It states that, regardless of the procurement route, it is essential that, as part of the briefing process, those involved in the provision of the facility are advised that all relevant guidance published by HFS was available electronically for purchase from HFS. It states that only by having knowledge of these requirements could a healthcare organisation's board and senior managers understand their duty of care to provide safe, efficient, effective and reliable systems which were critical in supporting direct patient care. It states that it was expected that appropriate governance arrangements would be put in place to reflect these responsibilities, supported by access to suitably qualified staff to provide the informed client role. It states that by locally interpreting and following the guidance, NHS boards and individual senior managers should be able to demonstrate compliance with their responsibilities.

9. SHTM 00 recommends (page 9) that boards and chief executives, as accountable officers, use the guidance and references provided, inter alia: when planning and designing new healthcare facilities; and when developing governance systems which take account of risk. The Executive Summary concludes by stating that "*Once NHS Boards and Chief Executives have embraced their principles set out within this document and taken the necessary actions, their duty of care responsibilities are more likely to be fulfilled".*

10. Both SHTM 00 and SHTM 03-01 carry a disclaimer in the following terms:

"*The contents of this document are provided by way of general guidance only at the time of its publication. Any party making use thereof or placing any reliance thereon shall do so only upon exercise of that party's own judgment as to the adequacy of the contents in the particular circumstances of its use and application. No warranty is given as to the accuracy, relevance or completeness of the contents of this document and Health Facilities Scotland, a Division of NHS National Services Scotland, shall have no responsibility for any errors in or omissions therefrom, or any use made of, or reliance placed upon, any of the contents of this document.*"