Scottish Hospitals Inquiry
Witness Statement of
Paul Serkis

WITNESS DETAILS

1. My name is Paul Christopher Serkis. I am currently employed as a project director at ISG, which is a construction company. I have worked there for just over one year.

2. I've been involved in construction for approximately 34 years. I started out with John Laing Construction who sponsored me through university whilst I did a quantity surveying degree at Liverpool University. I worked at John Laing for 13 years.

3. My first project was actually the Chelsea and Westminster Hospital in London, which was a management contract. I was working with John Laing during summer placements, whilst being sponsored through university as an apprentice surveyor. I also worked on South End Hospital, which was a design and build contract.

4. I left John Laing in 2001. The reason for this was that I'd been doing a part-time law course, and I got involved in some PFI contracts. This got me interested in the whole model and how PFI worked, and the number of stakeholders involved in that. I got an opportunity to go and work on school PFIs, which were just starting to take off in the early 2000s. I joined a company called Wates and worked with them for just under four years, doing predominantly PFI schools. The starting point was a Merton schools project, which was six schools in a bundle. I then progressed to looking after a number of schools and getting involved in the front-end bids of PFI.

5. I wanted to progress to hospital builds, and in 2005 a lot of UK hospitals were being built under the PFI model. I joined Multiplex that year as a commercial

director for public and private projects. I joined to help Multiplex bid for Peterborough Hospital's PFI, which was a combination of three NHS trusts that were merging together on the existing Edith Cavell Hospital in Peterborough. It was a circa £350 million PFI scheme. I also worked on the Queen Elizabeth University Hospital in Glasgow – which was just under £600 million (this was a capital expenditure ("CapEx") model, not a PFI).

6. I worked at Multiplex for 16 years. My role at Multiplex was to look after all of the healthcare projects to identify what opportunities we, as a business, could add value to and could get involved in to deliver off the back of all the good work we did in Peterborough and Glasgow. I would lead bids, get them set up, bring the teams together, manage teams, make sure that people were clear on the expectations, and trying to create what was a true public-private partnership between a number of organisations. I pride myself in being able to bring people together and work as a team. I would then hand over to others to build the project.

7. It was there that I became conversant with understanding how hospitals operate, understanding the user groups, understanding the clinicians, understanding how you put together a hospital, where you start with the departments and the adjacencies and then you build a wraparound of a building. My understanding is that the starting point is patient pathways and how you treat patients and the routes that they take through the hospital depending on why they are there.

8. This role gave me a real insight into the putting together a hospital from a design point of view, but also, equally, I could use my skills from managing, PFI projects, having delivered PFI projects from start to finish, understanding about availability and how PFI models work, and just having a general acknowledgement of how all these things are put together and the number of stakeholders.

9. The PFI model can be likened to paying for a facility through a mortgage as it spreads payments over a number of years, covering the capital cost, interest)

and on going maintenance for a set duration. It enables a user to have a new or upgraded facility built sooner to carry out providing their services.

10. The consortium is led by an SPV/SPC (Special Purpose Vehicle/Company) which is set up specifically for a project. This SPV will have usually been formed by the Equity Partners (for the RHSC Project, this was Macquarie Bank) who manage the bid process and their supply chain partners. Typically, you will have an SPV, a combination of equity and senior debt funders, a main contractor (for the design & build of the facility) and a facilities management Company (who manage the ongoing maintenance and life cycle replacement works for the duration of the agreement. The main documents are a Project Agreement (between the SPV and the Client,) a Design and Build Contract (between the SPV and the Main Contractor), an Operating Contract (between the SPV and the FM provider and an Interface Agreement (between the Main Contractor and the FM Provider).

11. Each party has differing obligations to comply with:

    a. the SPV – raising equity and securing senior debt funding and leading and maintaining dialogue with the Client at all times;

    b. the Main Contractor: the design and build of the facility; and

    c. the FM Provider: providing on-going maintenance and life cycle replacement to ensure all areas are “available for use” during the agreed period.

12. In 2013 when the PQQ process commenced, I became involved in the Royal Hospital for Young People/Department of Clinical Neurosciences (RHCYP/DCN) Non-Profit Distribution (NPD) build.

13. This project was my first experience of an NPD model. It’s not exactly the same as PFI or PPP, but it had all the same constituent parts - the SPV, the main contractor, the FM provider, the interface agreement, and the various legal advisors, insurers and other stakeholders involved.

RHCYP/DCN PROCUREMENT – MY ROLE

14. To be successful in a bid, you've got to get the money right to start with. That's a combination of capital expenditure for building the actual facility, the Facilities Management side inputting their life cycle and maintenance costs and management costs. The SPV will then carry out stress testing on the financial model to see how it all works, and whether the right numbers are there to make the bid competitive to even be considered to start with. Generally, although Macquarie would be able to speak to the specifics of this project, on a project of this type, equity providers (Macquarie on this project) will invest up to 10% of the funding and then seek senior debt from other funders for the remaining 90%.

15. If a bid is not on the money, then you'll very quickly get reduced to third place. So you've got to get the money right to start with. Then it's about where you can add value and whether you are compliant, by which I mean meeting the criteria set out in the scoring matrix.

16. My involvement in the project began at the point the project was put out to bidders. I was involved in putting the pre-qualification response together. This process was being managed by Macquarie as the shareholder of IHS Lothian ("IHSL") who were the SPV at the Project. Multiplex were one constituent part of the bid, as we were the design and build contractor, but Macquarie were very much in charge.

17. We were part of a team, but it was being managed and led by IHSL. We were one part of the jigsaw, sitting as the D&B contractor, with Bouygues as the FM provider and Macquarie as the owner of IHSL the SPV as the overarching leader. We had previously worked with Macquarie on the Peterborough Hospital, so there was a working relationship there. Macquarie led the bid and were the direct point of contact as IHSL lead. They attended meetings and were driving the process as one would expect typically from a consortium lead.

18. My role was to bring the construction team together, bringing all the different constituent parts of what we would do as the design and build contractor and to be the interface with Bouygues and Macquarie working with my colleague at the time, John Ballantyne.

19. John was based in Scotland, so the intention was for him to take the lead because he was going to stay and manage the project.

20. My role really was doing what I'd been doing on previous projects, which was to have a high level understanding of the overall Board's Construction Requirements, understand the projects, the time scales, who we needed to bring in in terms of our team, what expertise – if any – was required, and to knit that together and be the link between us Bouygues and Macquarie. John would then take over running the project during the design and construction phase.

21. So the challenge for me, which I enjoy, is bringing people together, knowing the subject matter as best I can. I don't claim to know everything about healthcare, but I have an understanding of the process, how the hospitals are built, the main suite of documents – Board Construction Requirements (BCRs), Project Co Proposals (PCPs) and that sort of thing. I won't necessarily know all of the detail and every single thing that's done, but it's more of an awareness and then having people to make sure that we're focused on doing that and delivering the constituent parts, and it wasn't easy on this project. The working relationship with the client was challenging. Many of the client team had been involved in the project for a few years by the time I became involved, and possibly fatigue had set in – they weren't keen to engage with us in manner which in my opinion was to create a high performing combined project team (public/private partnership model).

ENVIRONMENTAL MATRIX AND PRE-PREFERRED BIDDER/COMPETITIVE DIALOGUE STAGES

22. My understanding of an Environmental Matrix (EM) is you'll be set environmental conditions and parameters about how those rooms in a hospital

are going to feel from a temperature and a personal wellbeing feeling when you walk into that room.

23. I've mentioned earlier my understanding of hospitals and how they operate, but equally, I had a basic understanding of how the hospital could be set up: various types of wards, single bed occupancy, four-bed wards, dormitory wards and how those rooms operate. There are also Critical Care units, PICU, high dependence units, consultancy rooms and other separate units that operate differently to a dormitory or a single-bed room, and they've got different condition requirements. What I did gauge is from a personal point of view when you walk into one of those rooms you generally don't really notice that much difference. You wouldn't notice whether it's ten air changes, or six, or four, or two.

24. What I did also find is through a lot of research working with healthcare planners and designers – and we went over to Scandinavia to look at hospitals; we went over to Australia to look at hospitals – there is no right or wrong answer in how services should be delivered. It's how the particular hospital trust or hospital board want to deliver their medical services. They might want single bed occupancy in every room, or a blend of single bed and four-bedded wards. The latter can aid recover for those who do not want to be in a room on their own. I got interested in the healthcare side of it as well, to understand different journeys that patients took.

25. The EM gives you a set of parameters to work with. I have seen EMs used in other hospital builds that I was involved in previously, I suppose it is a mix. I don't think there is a normal approach. In the past you'd have a room datasheet where you do a typical room datasheet one for a ward, one for a single bed occupancy, one for Critical Care, PICU. So I wouldn't say that all the time you'd have an environmental matrix. The room datasheet was far more developed specific for that room and it had everything and it complemented what we call a 1:50 layout drawing with elevations and plans showing exactly where the bedhead units are going to go, what height on the walls where the electrical panels would go and where the sockets would be,

how many sockets you'd need in a room, what the environmental conditions were going to be in that room. So the room datasheet was probably more advanced, as opposed to the environmental matrix would have set parameters.

26. In theory, you should see a correlation between room data sheets and the EM, but the room data sheets may get changed because of how people perceive what the room will be used for or how it will operate allowing for any future proofing. For example, if you've got an overall floor plate on a level, and if during the course of design you might say actually that we want to introduce another couple of single bedrooms in there, you then need to move space from elsewhere, which you might do by changing the room usage or layouts. You then need to change that room datasheet to reflect the fact that you've changed its use. Then you have to reconfigure slightly the overall layout of that of that floor.

27. So the EM, shows the environmental parameters and the room data sheets are the next level down - you develop that design with the clinicians and with the user groups. It's very difficult to finalise those room datasheets until you absolutely have cast iron 100 per cent design freeze for that room. There is no rule for when this will happen, but typically its after financial close.

28. I did not have much detailed involvement with the EM in my role. It was just part of the suite of documents that made up the whole fabric of the hospital, and how it was being designed and delivered. There were technical people looking at the detail of it for me. This would have been Stuart McKechnie of Wallace Whittle and the team at Mercury Engineering. It was a case of, if I go back to what I said at the beginning, there's so many moving parts and so many different stakeholders. The EM was something I was aware of, and my understanding was that this was what the Board wanted, but I wouldn't say that I went and looked at it and reviewed it. As I've said above, those involved in the project to date (on the Board side) were pretty fatigued as they had been trying to progress this job for so long. They had a reference

design and we were being told, "Don't change any of it. Just get on with it and deliver it. We don't want anything else." This is my firm recollection of what we were being told by the Board and their advisors Mott MacDonald. They just said "This is what we want. We've spent enough time modelling this. We've met with the user groups. We've met with the clinicians. Please don't change it, just deliver what we want." I remember turning to my colleague, John Ballantyne, after one of the competitive dialogue meetings and saying to him something along the lines of "Well, there's not much scope for us to add any value here. We've just got to comply with what they're asking because they're not for changing. They don't want to change anything." By this, I meant we would need to meet the requirements set out in the briefing documents such as the EM ***(A32623039, Environmental Matrix dated 4 September 2014[1]).***

29. We were attending competitive dialogue meetings at the end of 2013/early 2014. They were very regimented. The Board stuck to a very rigid process, and that's the right and proper way to do it, but it was very cold and it didn't feel like a nice environment to work in. The impression from those meetings was just, "This is what we want. Get through it. We'll make our decision. We want it built." I can't remember the exact number of meetings, but there would have been sub-meetings on the different workstreams. There was one for design, one for legal, one for FM, one for the interface between construction and FM. The meetings were around 90 minutes long, and the dialogue was pretty much one way - the Board were telling us what they wanted. I could not go to all of these meetings. I went to some of them, and John Ballantyne went to some because some sub-meetings were going on at the same time. They were not dialogue meetings of the sort that I was used to. Normally, meetings of this type would be a dialogue between two groups of people, "Okay, you've said you want this, and we could do that. Here's some things you might want to consider. Here's some things that we can work with should we be selected for the next stage." That was cut down pretty quickly after the first meeting. It was a case of the Board stating, "This is what we want, don't change it." These dialogue meetings were formulaic at best. We had the Queen Elizabeth University Hospital Project in Glasgow development behind us, but I

[1] Bundle 4 - Environmental Matrix, Item 1, P4

found, very quickly, that we were not to mention Glasgow. The Board didn't want to hear anything about what we had done there and that was made clear.

30. I said to John that this was going to be a difficult project. I was used to dealing with people where we could build a relationship to work together for the coming years, and it didn't come across like that to start with on this project. Brian Currie was leading from the Board's side and had a team beneath him. I am not saying they were horrible; it was just very cold. This stood out as quite different to what I was used to. I had not come into a project like this where there was already a firm design that had to be followed. You would have what I call the public sector comparison where you would work with the design teams, and you'd work with the clinicians, and you'd have the user group meetings to develop those further. So on Peterborough and on Glasgow there was a very good rapport with the NHS boards, their representatives and the user groups and the clinicians. That didn't exist here – there was no real desire on the Board's part to work in partnership or entertain any suggested changes to the design.

31. In terms of my understanding as to why a reference design was used, it was that they had already had user group meetings, they had sorted out how they were going to deliver the services, and then you had a bolt on with the DCN that had been brought together as part of the overall deal. That was another change the Board had had to deal with, and I just felt that they had made their mind up about what they wanted. That was clear in the documents from my recollection.

32. On Peterborough we built a mock-up of what a ward would look like so that we could take the nurses and the people that were going to be using that to get a sense of spatial awareness, because whilst we could show them 2D drawings at the time, when you take someone into a mock-up in a room they get a much better sense of scale and how that room might look. Whereas here, it seemed like they'd had all those meetings, they'd decided what they wanted, and that was it.

33. Multiplex did not have much contact with clinicians throughout this project. That's unusual for me. If you are involved from the inception of a project, you work very closely with the clinicians. With this project, I did not get that sense of relationship building or even wanting to.

ROLE AT THE PREFERRED BIDDER STAGE TO FINANCIAL CLOSE

34. At preferred bidder stage I indicated to John that we should try and build the relationships, but it just didn't happen. I remember saying to John, you're going to have your work cut out here delivering this job.

35. I am asked about a requirement of the appointment as preferred bidder to provide room datasheets. I didn't get involved in the detail on that, there would have been Mercury Engineering who were our MEP contractor and Wallace Whittle as our MEP advisors. We also had people working in the Multiplex team: Lianne Edwards and Ken Hall. However, my experience is that it is not normal for a client to request or seek 100% of the room data sheets are in place at Financial Close.

36. I cannot speak to ventilation systems. I wouldn't have got involved in the sort of day-to-day detailed understanding because there were people doing all of that and looking at all of that. I was aware of it, and I was aware of the documents and the names, and you get to learn the jargon and the understanding. My appreciation of how a hospital operated and how units operated was very high level, but I couldn't go into the ins and outs and say that particular room has these types of conditions, has these types of air changes, has this type of cooling, has this type of ventilation.

37. Up to preferred bidder stage, I did not have any concerns about the EM or any of the documents around the ventilation requirements. I don't recall the Board raising anything major. Mott MacDonald were in attendance at the dialogue meetings – Richard Cantlay and Graeme Greer. They were there to support Brian Currie and his team – that team included Sorrel Cosens and Janice Mackenzie.

38. At preferred bidder stage we set about a programme as to how we're going to get from preferred bidder to financial close with the Board and their advisors. As part of this, you map out all the different workstreams and who's doing what. You allocate resources to make sure that you meet that programme. This was done by Macquarie as they were the lead from the IHSL side, but we had an input in that process.

39. At the time, I felt that there was enough time from preferred bidder to intended financial close to do what we thought we needed to do but, from recollection, it ended up just dragging on and on and on. There were frustrations on our part which were partly to do with the Board trying to shoehorn more and more information into the documentation. In terms of what we thought we needed to do, you'd have a list of deliverables that you would agree in advance, and you try and stick to that. As part of that you would have a review of the Board's Construction Requirements ***(A33405670, Schedule Part 6: Construction matters, section 3 (Board's Construction Requirements), Subsections A, B and C Excerpt pages 1 to 149[2], A41179262, Schedule Part 6: Construction matters, section 3 (Board's Construction Requirements), Subsection D Excerpt pages 360 to 780[3]),*** the provision of some typical details, the provision of some layout drawings and the provision of some specifications. Then you'd have the interface with the FM so that they were aware of what the make-up of the building was, so that they could price their life cycle model and their maintenance regime and the protocols that go around that. Then the SPV company would have their deliverables in terms of the financial model, making sure the interface agreement is done, the legal side, the insurance etc.

40. There are hundreds of documents involved in this process. There are more documents than there would typically be if you're just doing a straightforward CapEx job, but we were used to that and so the timescales at the time didn't seem onerous. I think this is where if you had a team, everyone, whether it's client team or the consortium, working together in harmony, then you get a much better outcome and you are more likely to maintain momentum and keep to the programme. I just didn't feel that there was that approach here. It

[2] Bundle 5 - Contract Documents, Item 3, P192
[3] Bundle 5 - Contract Documents, Item 4, P341

was frosty and hard work.

41. We had a number of individuals on-site, working with the Board and other parties. We were based in an office next to them on Canaan Lane. You try and co-locate to get the best out of everyone and get everyone working together.

42. I did not sit in on any of the user group meetings. However, I had an oversight role and we would meet with Brian Currie and his team. We'd have what we call a "town hall meeting" where everyone was together at the beginning of the day. I don't have the details of these meetings, but I suspect the Board or IHSL might. They were meetings at the beginning of the day when we had a series of meetings. Everyone would meet at the beginning and then everyone would go off to their respective disciplines, go and have their meetings, and then come back at the end of the day or the next day and feed back into how things were progressing, whether that was legal, insurance, construction or FM. I'd sit in on the town hall meetings. They gave a feeling for how things were going, and it was evident that things were not going as well as we wanted. The period to financial close dragged on. At the end of the day, we wanted to build it and get on with it, but it was just hard work.

43. I wasn't attending the workstream meetings. I might dip in and out just to check how things were going. I think that relationships were one of the issues causing matters to drag on. There was a huge amount of scrutiny of the documentation and a lot of what I perceived to be extra that Motts and the client team were wanting from everyone, not just construction, but from FM and the SPV as well. That sort of message was coming back from all parts of the team.

44. On a project like this, you get to financial close, and you pretty much know what you've got to build. However, there's inevitably going to be some detailed design development going on beyond that. There's going to be further meetings as the project goes on because you're working as a team. There's an element of design development that goes on beyond financial close.

45. There is also an element of logistics that may or may not change depending on the site and how it's operating and we're putting together those logistics. The FM team are looking at what material selections are being made and then they can base their life cycle and their maintenance regimes. You'll need to establish, for example, what heating and cooling is going to go into those areas, the design of the lights, and making sure that they've got Passive Infra-Red detectors that they switch off. There will be things that need to be done post financial close, which is completely normal.

46. You accept that there's a certain element of flexibility that you still need to have before you get to the eventual point where you are locking down the design freeze with the 1:200 layouts and then you'd move to the 1:50 layouts. If there's a will and a desire from everyone, those things can get sorted or you have provision to say, "Right within X date, we can sort that out post financial close, not a problem." But this was, "We want everything battened down," you cannot so much as do anything without this being written into the Project Company Proposals (PCP). I remember the PCP had been a major bone of contention and my colleague Liane Edwards, being frustrated trying to co-ordinate these things. When you put a draft PCP in, normally you would expect a couple of light touches and a markup and then you agree with the client that document's put in and then you move on. However, from what my recollection was, the Board and their advisors were going through every item, changing it, not only changing words and grammar but also changing the fundamentals of what we said in some instances. This was altering the basis of the bid which they had accepted.

47. I do recall us going through this whole process and there was a massive frustration. I can't remember the exact details, but I just know the PCPs kept coming up as being a source of frustration. I guess that was probably both sides because you've got one side (the Board) wanting to shoehorn everything in and IHSL trying to meet a programme and they're (The Board) sending many iterations of our PCP's. We had a tracker with all of the PCPs listed out. I recall that I actually drafted one of the trackers to help the team and I sent that to the Board thinking "Right, okay, that should be okay," and it

came back and it was like a teacher had marked up my work with red pen. I then got a sense of the frustration our team were feeling. I'm not saying I wrote the best piece of work on this one particular bit, but I wasn't expecting to get a teacher put a red line the whole way through and mark the whole thing up.

48. PCPs were our response to the BCRs, essentially setting out how we would deliver what they had asked for. If I'd had my way, we would have rewritten the BCRs, but they just were not entertaining that at all. The reason for this was that those BCRs were written in 2010, maybe even before that. We could have taken out the aspirations that were held then and replaced that with what had been agreed between the parties. They wanted the PCPs so absolutely respond to every single item in there. That was not normal. I am not used to that. It was going above and beyond, and actually coming to the point where the Board were becoming so controlling about everything that the team were getting really frustrated. I think this fed into the delay in reaching financial close. I'm sure this would have been discussed in meetings at the time. It just didn't feel like there was any trust.

49. There were financial concerns about getting to financial close. The scheme the Board wanted still had to meet the price agreed. You set a plan and we all try and stick to that and the sequences we've gone through – the pre-qual to competitive dialogue – all of that had worked in accordance with the timings.

50. It just didn't seem like that. It was more like the Board were more concerned about making sure they dotted every single "i" and crossed every single "t" and shoehorned in anything they could possibly think of. If we had had a team working collectively, then everyone, both sides working together, we could have reached that original date. But with everything that was going on with some of the issues, the goalposts changing, it just didn't happen. Then, you know what it's like when things get delayed and then people are trying to blame each other for "Why hasn't that happened?"

51. There was an occasion where I was on holiday and my Managing Director, Ross Ballingall, had to go up there to a meeting so I had to brief him. John

and I were feeding information back to him. I rang him from my holiday to ask how the meeting had gone. He said, “We’ve just got to cut through all the white noise and just get to financial close because this is going to drag on and on.” I said, “I know, Ross,” and that’s where the frustration was. I think, because I’ve worked with Ross on a number of projects before, he could see the frustration that I was getting as well.

52. This meeting took place in late August 2014. They called Ross up, I think, because we weren’t collectively going to obtain financial close. So they called Ross and Macquarie’s representatives. Steering Group meetings were attended by senior people, those ranked above us.

53. Regarding the amount of Reviewable Design Data (RDD) at financial close there’s always an element of RDD that will carry on beyond financial close and that’s typical of a project of this size and scale. You would expect that; you’re working to a different time scale, i.e. you’ve got to close things out in order to get it built. So there’s a perceived acceptance maybe from some parties that, well, if financial close slips a bit, then so be it. Whereas when you start building and you’ve got an end date, that’s what’s out in the public domain. That’s when it’s going to get built, you’ve got people moving from different parts of Edinburgh from other hospitals that are being shut so they can move into the new facility. We just wanted to get on and get that deal closed so that we could start building. Then you deal with the RDD elements, and you deal with the day-to-day issues, but you manage your way through it, and you build out and you deliver it, and you have the quality there and that’s it. My experience is that it is more common for final RDD and EM to be agreed after financial close.

GUIDANCE VERSUS CONTRACT

54. In terms of what document takes precedence, most of that would have been dealt with by the legal team. The real devil in the detail of what you want is all in the schedules that sit behind the contract: that's your drawings, your

requirements, your specifications, your technical notes. All those things are basically what we are providing and what the client is buying.

55. We were just part of the jigsaw – there would have been that triangulation between Macquarie, Multiplex and Bouygues. Everyone's feeding into making sure that we are responding to whatever we've been asked to and putting the offer back such that hopefully it's accepted by the client.

Closing Statement

56. 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.