Scottish Hospitals Inquiry

Witness Statement of

Professor Fiona McQueen

Introduction

1. My name is Fiona McQueen. I am now semi-retired. I was formerly the Chief Nursing Officer (CNO) for Scotland.

2. This statement addresses:

    a. My professional qualifications and background
    b. Escalation of NHS Lothian (NHSL) and Appointment of the Oversight Board
    c. Appointment as Chair of the Oversight Board
    d. Role as Chair of the Oversight Board
    e. Supplementary Agreement 2 (SA2)
    f. Phased Migration
    g. Covid/Brexit
    h. Full Migration
    i. Communications with Cabinet Secretary
    j. Some reflections on my involvement with the Royal Hospital for Children and Young Persons/ Department of Clinical Neurosciences (RHCYP/DCN project).

Professional Qualifications and background

3. I am a registered nurse with a Diploma in Management Studies, a Masters Degree in Business Administration and a Degree in Nursing Studies.

4. I am semi-retired. I am a member of the Scottish Police Authority and I am also the Chair of the Ayrshire College Board. A copy of my CV is produced at

(A47200263 – Fiona McQueen – Curriculum Vitae – Bundle 13 – Volume 4 – Page 1333)

5. Between November 2014 and April 2021, I was the CNO for Scotland. As CNO I was responsible for overseeing the work of the Chief Nursing Directorate; a Scottish Government Healthcare Directorate responsible for achieving the best health and care outcomes for people by working on patient, public and health professions policy, and support ministers and the NHS in delivering a safe, effective and person-centred health and social care system.

6. The CNO Directorate has a wide remit including responsibility for:

   a. student nurse and midwife intake
   b. leading on nursing, midwifery, allied health professions and health-care science
   c. modernising and improving NMAHP (Nursing, midwifery and allied health professionals) and HCS (healthcare support) services and standards of practice
   d. leading on all aspects of healthcare-associated infection policy and antimicrobial resistance and
   e. leading on health professionals and workforce regulation.

   The CNO Directorate is responsible for providing Minsiters with policy advice in relation to all of the aforementioned 'policy' areas.

Escalation of NHSL and Appointment of the Oversight Board

7. I first became involved with the Royal Hospital for Children and Young People/Department of Clinical Neurosciences (RHCYP/DCN) project following my return to work after a period of absence between June 2019 and August 2019. By that time, an Oversight Board had been established and the CNO was a member of the Board. I explain the function of the Oversight Board in more detail below.

8. The Scottish Government is responsible for the NHS in Scotland. Healthcare is delivered at a local level by the Scottish health boards. Those boards are subject to performance monitoring by the Scottish Government. The Scottish Government's NHS Scotland: support and intervention framework (the Escalation Framework) is one of the key elements of the performance monitoring processes.

9. The Escalation Framework provides a model for provision of Scottish Government support. The higher the level of escalation the greater the level of support the health board is given. The current framework can be found at **(A46674602 - NHS Scotland: support and intervention framework - as updated to 27 November 2023 – Bundle13 – Volume 3 – Page 687)**

10. On 10 July 2019 NHSL were escalated to Level 3 of the Escalation Framework. This was communicated to NHSL in a letter from Malcolm Wright, the then Director General for Social Care and Chief Executive of NHS Scotland, dated 12 July 2019 **(A41263551 - Letter to Tim Davison, copying in Brian Houston, from Malcolm Wright – 12 July 2019 - Bundle 7 - Volume 1 - Page 339)**. I was not involved in this decision to escalate as I was absent from work at the time the decision was made. However, as is apparent from Malcolm's letter, escalation to level 3 related to NHSL's performance across a number of areas of healthcare delivery.

11. In consequence of NHSL's escalation, an Oversight Board and Oversight Group was established. The Oversight Board related to delivery of the RHCYP/DCN project. The Oversight Group, chaired by Professor John Connaghan, focused on improving performance across a number of different health care deliverables.

12. The Oversight Board's terms of reference can be found at Inquiry document **(A41232145 – NHS Lothian RHCYP Oversight Board_ToR – Bundle 7 - Volume 2 - Page 354.)** Those terms of reference define the scope of the Oversight Board's work as:

"The Oversight Board will provide advice in relation to:

- Advice on phased occupation
- Advice on the proposed solution for ventilation in critical care areas and on any other areas that require rectification works
- Advice on facility and operational readiness to migrate
- Gain information and give advice to NHS Lothian about commercial arrangements with IHSL for completion of works
- The approach to NPD contract management
- Identification of areas that could be done differently in future."

13. The original members of the oversight board were:

- Christine McLaughlin, Chief Finance Officer, Scottish Government
- Catherine Calderwood, Chief Medical Officer, Scottish Government
- Prof Fiona McQueen, Chief Nursing Officer, Scottish Government
- Susan Goldsmith, Director of Finance, NHS Lothian
- Tracey Gillies, Executive Medical Director, NHS Lothian
- Prof Alex McMahon, Nurse Director, NHS Lothian
- Peter Reekie, Chief Executive, Scottish Futures Trust
- Colin Sinclair, Chief Executive, NHS National Services Scotland
- Alex Joyce, representative from NHS Lothian Joint Staff Side (deputy Gordon Archibald)

14. Attending the Board to provide advice and assurance was:

- Mary Morgan, Senior Programme Director
- Brian Currie, Project Director, NHS Lothian
- Judith Mackay, Director of Communications, NHS Lothian
- Prof Jacqui Reilly, HAI executive lead for NHS National Services Scotland and

- SRO for centre of excellence work
- Gordon James, Health Facilities Scotland, NHS National Services Scotland
- IHSL would be in attendance on an 'as required' basis

15. The first meeting of the Oversight Board took place on 8 August 2019 and was chaired by Christine McLaughlin. The Oversight Board met weekly between 22 August 2019 and 31 October 2019. This was the period of most intense activity on the project. Thereafter, and as the project advanced towards completion, the oversight board met fortnightly. The final meeting of the Oversight Board was 8 April 2021 following opening of the RHCYP/DCN in full on 23 March 2021.

16. On 13 September 2019 NHSL were escalated to level 4 on the Escalation Framework in respect of the RHCYP/DCN Project. This escalation was communicated to NHSL by letter from Malcolm Wright of the same date **(A44267042 - Letter – MW – B Houston and T Davison – NHS Lothian Level 4 Escalation – Sept 2019 Bundle 13 - Volume 3 - Page 702).** Escalation to level 4 resulted in the appointment of Mary Morgan as Senior Programme Director. Mary Morgan is now the Chief Executive of NHS NSS. In September 2019 Mary Morgan was Director of Strategy, Performance and Service Transformation at NHS NSS. Mary reported to the Oversight Board. I was not involved in the decision to escalate NHSL to level 4.

17. Mary Morgan reported to the Oversight Board via her Senior Programme Director's Report. Mary would also attend the meetings of the Oversight Board, and advise on anything she was concerned about. In between meetings, Mary would pick up the phone to brief me on any concerns she had. The Oversight Board had a plan and timescales for when things should be completed by. The timescales would alter and this was dependent on whether there were any outbreaks of COVID and whether we could negotiate challenges.

18. Mary would brief the Oversight Board on progress of the project. She was very professional, robust, and dependable. At the Oversight Board we would

request evidence for any updates we were provided with. Mary would provide evidence by reference to, for example, reports from NHS NSS or NHSL. She would provide a rationale between the red, amber, green stages of her reports. She was a key member of staff who oversaw the delivery of what needed to be done. The Oversight Board had a plan and timescales for when things should be completed by. The timescales would alter depending on the challenges faced by the project, for example, by an outbreak of COVID amongst the workforce. Mary would keep the Oversight Board briefed on such 'operational' matters.

Appointment as Chair of the Oversight Board

19. Diane Murray had been deputising as Chief Nursing Officer in my absence. Accordingly, Diane had attended the first meeting of the Oversight Board. On my return to work Diane briefed me on the work and operation of the Oversight Board. I then attended meetings of the Oversight Board as a member between 22 August 2019 and 10 September 2019. On 10 October 2019 I attended my first meeting of the Oversight Board as its Chair. I remained Chair until the Oversight Board's final meeting.

20. I have been asked by the Inquiry at what point I was made aware that I would be Chair of the Oversight Board. On my return to work Christine McLaughlin advised me that it had been thought appropriate that I would take over as Chair and I was happy to do so. At the time, Christine was the Chief Finance Officer for NHS Scotland, and Director of Health Finance, Corporate Governance. Christine's directorate is involved with overseeing NHS Scotland capital programmes, including delivery of the RHCYP/DCN project. It therefore seemed sensible for a more neutral person to sit as Chair. This would then give Christine the freedom to contribute to the Oversight Board as a member rather than having to take a slightly more impartial position as Chair.

Role as Chair of the Oversight Board

21. I have been asked what I saw the role as Chair of the Oversight Board to be. The role of the Chair is to oversee delivery of the work of the Oversight Board as set out in its terms of reference (see discussion at paragraph 11 above). I considered that, at a high level, performance of this role involved balancing patient safety and the economic implications of delivering the RHCYP/DCN project.

22. In relation to patient safety, it was important to have regard to both the patients then in the old facilities and the safety of the patients moving into the new facility.

23. I was also cognisant that the RHCYP/DCN project was a publicly funded project. Practical completion had been reached and the unitary charge was being paid to IHSL for a building that was not providing the healthcare services it was designed for.

24. I was concerned, in my role as Chair, with public confidence in the project. Public confidence, in terms of wanting to move into a state of the art building as efficiently and as economically as was possible, but also public confidence that the facility was safe for the delivery of patient care. I was also cognisant of the Oversight Board's function of providing assurance to Ministers and the accountability of those Ministers to Parliament.

25. I was also aware that the project was being delivered under the NPD financial model. This meant that there were commercial nuances to be considered when decision making. For example, the requirement for IHSL's funders to ratify agreements made in relation to Supplemental Agreement 2 (SA2) **(A32469196 – Project Agreement Supplementary Agreement (No. 2) – 5 August 2020 - Bundle 3 - Page 1204)**. (The supplemental agreement addressing, amongst other things, the remedial works to the ventilation system in the critical care unit). As Chair, the role was about keeping that balance, moving forward as

quickly as possible and making sure that all of the details and interests that needed to be taken into account were taken into account.

26. I have been asked by the Inquiry about the decision making processes of the Oversight Board. In particular, I have been asked if, as Chair, decision making was my responsibility or if the Oversight Board adopted a more balanced process. The members of the Oversight Board worked collaboratively to make decisions. It would not be correct to consider my role as Chair to be akin to a form presidential decision making.

27. The composition of the Oversight Board was such that the different members (and attendees) brought with them different skillsets and expertise. Different members had different areas of expertise, but the strength of the board was its collective knowledge and skill. For example, Tracey Gillies (Executive Medical Director for NHSL) provided advice on patient safety (alongside those members and attendees from NHS NSS). Alex McMahon (then NHSL Executive Nurse) and Tracey Gillies provided advice on service delivery and staffing, such as recruitment and retention. Susan Goldsmith (NHSL Director of Finance) would provide advice in relation to commercial arrangements and negotiations, as well as Peter Reekie of Scottish Futures Trust. I would always look to draw on relevant expertise on the Oversight Board and make on-balance, collaborative decisions. If we could not get an on-balance decision in the time available during the meetings, I would ask the relevant people to engage in further discussions and revert with a reasoned decision. I expressed that such discussions should have patient safety at their core. On occasion, relevant persons would hold ‘workshops’ involving, for example NHSL infection prevention control and NHS NSS. At these workshops the attendees would investigate concerns with a view to gathering evidence and coming to a decision on a relevant contentious matter.

28. I have been asked by the Inquiry if the NHS NSS report was the guide for the Oversight Board in terms of what needed to be looked into and what had to be taken forward. Yes, I would say it formed part of the plan, or it at least gave us the architecture for what we needed to take forward. As Chair, I took the high-

level view that once the issues raised in ventilation in the critical care unit and the matters raised in the NHS NSS report had been addressed then the hospital should be safe to open to patients.

29. At the initial meetings of the Oversight Board the only significant issue that was known to require remediation at the time was the ventilation in the critical care unit at RHCYP. My understanding was that there were other problems but they would have been considered to be routine snagging. Following receipt of the NHS NSS review in relation to water, ventilation, drainage, plumbing, fire, electrical and medical gasses, the Oversight Board was aware of additional remedial works that were required beyond the ventilation systems.

Supplemental Agreement 2 (SA2)

30. I have been asked by the Inquiry about whether I considered there were challenges negotiating and agreeing Supplementary Agreement 2 (SA2).

31. SA2 involved negotiating the delivery of the remedial works in relation to, principally, the ventilation system at the critical care unit of the RHCYP. The works were complex as was the contractual nexus within which they require to be delivered.

32. There were a number of different parties involved in the negotiation of SA2 and each party had a different commercial interest which brought an element of complexity. NHSL had the responsibility for moving the project forward so that the new facilities could be opened. Integrated Health Solutions Limited (IHSL), as Project Co under the NPD contract were responsible for delivering a viable healthcare facility. IHSL, however, had responsibilities to its funders who each had their own commercial stake in the project. There were also the contractors: Multiplex who were responsible for construction and Bouygues who were responsible for providing facilities services once practical completion had been reached.

33. I recall that, as Chair of the Oversight Board, I was frustrated that negotiation of SA2 was not more straightforward. I knew that I wanted the project to be delivered as safely and economically as was possible. However, the responsibility for negotiating how that was delivered rested with others and could not simply be directed by the Oversight Board. That being the case, the focus of the Oversight Board was to ensure that those who were responsible for delivering SA2 (NHSL and IHSL) were as focussed as they possibly could be.

34. I have been asked by the Inquiry if the Oversight Board found it difficult to find a supplier to undertake the remedial works to the ventilation systems at the RHCYP. The responsibility for identifying and instructing remedial works rested with NHSL and IHSL not the Oversight Board. Mary Morgan would be better placed to explain this part of delivery of the project.

Phased Migration

35. I have been asked by the Inquiry about the decision to open the RHCYP/DCN by way of phased migration.

36. I thought it was appropriate to take a proportionate decision when deciding to open the new facilities. In essence, this involved balancing the need to open the hospital as quickly as was possible against the problems associated with doing so alongside ongoing works. The remedial works would have disrupted the delivery of patient care but, equally, until the new hospital opened, patients continued to receive care in outdated facilities. Ultimately, we had to determine whether or not there was increased risk to patient safety in having the construction workforce within clinical areas in order to form a view as to whether it would be safer to move the patients after the work was completed or not.

37. There was perhaps a greater need to migrate the Department of Clinical Neurosciences (DCN) from the Western General Hospital than there was to move The Royal Hospital for Sick Children (Sick Kids Hospital) from its site at Sciennes. I say this because the disparity between what was being offered at

the old and new facilities was greater at the DCN than it was at the Sick Kids Hospital. While steps were taken to improve the DCN at the Western General by, for example, installing new imaging equipment, it was recognised by all that the sooner services were migrated to the new building the better.

38. I have been asked by the Inquiry what featured in the decision making as regards phased migration. A number of factors featured in the decision-making process: patient and building safety, patient experience, staff availability, availability of medical resources and equipment and patient transport (amongst others). The Oversight Board was guided by its members when making decisions to phase migration to the new site. As is clear from the minutes, the Oversight Board received particular assistance from the 'phased migration' reports prepared by NHSL. See for example, **(A46527566 - DCN Phase 2 Migration: Review of the 6 Week Commissioning Period – 4 June 2020 – Bundle 13 - Volume 4 - Page 693)** and **(A46527584 - Partial Move of RHCYP OPD, Therapies and Admin to RHCYP+DCN Building Early July 2020 – 4 June 2020 Bundle 13 - Volume 4 - Page 696)**. The Oversight Board also received advice from NHS NSS on appropriateness (and therefore safety) of the works done and relied on their advice and interpretation of reports to determine a 'go' or 'no go' decision.

39. I have been asked by the Inquiry if I was involved in assessments related to delivery of healthcare services at the Sick Kids Hospital in Sciennes.

40. On 10 October 2019 I visited the Sick Kids Hospital and the DCN with the Cabinet Secretary. I understand that the Cabinet Secretary had previously visited the facilities while I was absent. My visit allowed me to observe the services being delivered in the hospitals first hand.

41. The Cabinet Secretary asked Healthcare Improvement Scotland into DCN and the Sick Kids Hospital to carry out an inspection to provide assurance of patient safety with regard to infection prevention and control at both sites. Healthcare Improvement Scotland carried out unannounced visits at the DCN and Sick Kids Hospital during 22 and 24 October 2019. These visits were discussed at the Oversight Board meeting of 24 October 2019. **(A33888205 – 6.2 0045**

RHCYP DCN IMT-ESG Minutes 2019-2021 – 24 October 2019, Bundle 13, Volume 4, Page 742). I was provided with the embargoed report from Healthcare Improvement Scotland on 10 January 2020. The report was then published on the Healthcare Improvement Scotland website at 10am on 15 January 2020. During this attendance clinicians had an opportunity to have their voice heard as regards improvements that could be made to the existing facilities pending migration to the new hospital. At Sciennes, the clinicians asked for extra room within the Emergency Department. The extra room was provided by removing an internal pillar and relocating outpatient appointments. I understand that this made a big difference to the staff. At the DCN, the main change was the provision of new imaging equipment that replaced older unreliable equipment.

COVID & Brexit

42. I have been asked by the Inquiry what impact COVID had on the project and what challenges, if any, it brought.

43. In my view, both COVID and Brexit limited the supply of goods available to the RHCYP/DCN project. This supply chain disruption impacted the speed at which remedial works could be undertaken. Put simply, if materials were not available construction could not continue.

44. The project's workforce was also impacted by COVID. Delivery of the project was considered to be of strategic importance so work did not stop during lockdowns, however, working methods and processes had to be adapted so as to incorporate social distancing which limited the number of workers who could be in particular parts of the site at any given time. There were also outbreaks of COVID amongst the workforce that impacted resource when those working on the project were self-isolating.

45. COVID also diverted clinical and technical resource from the project. For example, those at NHSL and NHS NSS with responsibilities for infection

prevention control were focussed on responding to the challenges presented by COVID and not on delivery of the project.

Full Migration

46. The RHCYP/DCN was fully opened on 23 March 2021. I have been asked by the Inquiry if I considered that, by this point, the hospital was a safe environment and whether I had any concerns over patient safety and care at that time.

47. The provision of healthcare is not risk free. No matter how safe and effective you make your building, once you put patients and staff into it, there is an interaction with the building that means proportionate risk-based approaches need to be taken at all times. Nonetheless, I was content on the basis of the evidence presented to the Oversight Board (including consideration of that evidence by persons with technical expertise at NHS NSS), that patients and staff could safely migrate to the new building.

Communication with Cabinet Secretary

48. I have been asked by the Inquiry if I had direct contact with the Cabinet Secretary in order to discuss progress of the project or whether she was happy to be kept in the loop via the Oversight Board and the different mechanisms with her civil servants.

49. Ms Freeman was very attentive to her brief, and, if anything, she liked more information rather than less. If, as a civil servant, you had a decision about whether or not to brief your minister about something, I would say you would make the decision to brief Ms Freeman. Ms Freeman was very interested in the work of the Oversight Board and I believe she was briefed after most meetings through her private office. Ms Freeman was also keen to keep Parliament and MSPs updated.

50. It would usually be Alan Morrison, Calum Henderson or their colleagues that would prepare the briefings that were given to the Cabinet Secretary following on from the Oversight Board meetings.

51. At the outset, there were weekly meetings with the Cabinet Secretary in the Scottish Parliament with Health and Social Care officials which gave an opportunity to keep her up to date on the work of the Oversight Board. In addition, I would find it helpful to alert Ms Freeman on an ad hoc basis to the fact that there was information she needed to know and then a written note would be sent to her. Any such note was usually sent after the Oversight Board meeting but not always.

52. I have been asked by the Inquiry if I received a request from the Cabinet Secretary to review and update the technical data regarding the ventilation given there were concerns that it could be interpreted differently by persons using it. I do not recall receiving such a request. Updating guidance is a matter principally for NHS NSS not the CNO Directorate.

Reflections

53. I have been asked by the Inquiry if I feel that everything went as well as it could have done from the point that I became involved. On reflection, I consider there could have been a sharper focus from NHSL to move forwards and to find solutions. It is easy with hindsight to say this because they were, of course, accountable for what had happened. There was an element of thoughtfulness from NHSL in that they had made a mistake already and therefore considered how they were going to make sure they could get the best possible solution out of this. When the new Chief Executive and Chair were appointed, processes improved and pace increased.

54. We did not have a representative of the public or patients on the Oversight Board, but perhaps a more formal route to hear from a patient's perspective would have been helpful. However, we did have input from the NHSL's Nurse Director and Medical Director so that we could have a sense of what was

happening with service delivery. On balance, I think it went as well as it could. Given that one can always improve, I think around the Oversight Board's table there was a commitment from everyone there that we agreed what needed to be done and we wanted to have it done as quickly and as soon as possible. There was also a fair balance of technical and medical people working together which, for a project like this, was essential.

55. I have been asked by the Inquiry if I felt that it was beneficial to have more Scottish Government involvement in the project rather than being kept at arm's length. I consider the traction that the Oversight Board put on NHSL and the appointment of Mary Morgan, both instituted by the Scottish Government's escalation of NHSL, was necessary. I believe delivery of the project would have taken longer if there had not been additional involvement from the Government.

56. I have been asked by the Inquiry if we have now got a better building than what was initially designed. My answer would be yes. It is so clearly better in terms of the ventilation within critical care and haemato-oncology and we have also seen improvements in and around prevention of water contamination and fire damper safety.

57. I have been asked by the Inquiry if there was anything that I would have done differently. IHSL's funders could have walked away from the project and there was always a balance to be struck as to how to move IHSL forward and how to limit this risk. In my view, NHSL could have been a bit more focused on trying to move the commercials on. However, they were navigating across a number of areas, and I recognise that was a delicate balance in this respect. External factors to the project also had a negative impact; Brexit and Covid added delay and complexity.

Declaration

58. 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.