SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
26 February 2024

Day 13
15 March 2024
Malcolm Wright

C O N T E N T S

10:03

THE CHAIR: Good morning. I think we have one witness, Mr McClelland?

MR MCCLELLAND: One witness today, Malcolm Wright, my Lord.

THE CHAIR: Malcolm Wright. Good morning, Mr Wright.

THE WITNESS: Good morning.

THE CHAIR: As you understand, you are about to be asked questions by Mr McClelland, who is sitting opposite you but, first of all, I understand you are agreeable to take the oath?

THE WITNESS: Yes.

Mr Malcolm Wright

Sworn

THE CHAIR: Thank you. Thank you very much, Mr Wright. Now, I do not know how long your evidence will take. We sit in the morning between ten and taking a lunchbreak at one, but our practice is to break for coffee at about half past eleven. However, if you want to take a break at any time for any reason, just give me an indication and we will take the break. Bear in mind, quite a large space to fill. People want to hear your evidence, and maybe a little bit louder and a little bit slower than conversation.

THE WITNESS: Okay, thank you.

THE CHAIR: Right. Mr McClelland?

Questioned by Mr McClelland

Q Thank you, my Lord. Good morning.

A Good morning.

Q Could I ask you, please, just to confirm your name?

A Malcolm Wright.

Q And you have provided a witness statement to the Inquiry. Is that correct?

A Yes.

Q Could we please have up on screen witness statement bundle volume 1 at page 278? Do you see there on the screen in front of you, Mr Wright, your witness statement?

A I do.

Q Now, I understand that there is a change that you wish to make in the statement to correct a typographical error?

A Yes, that's correct. It's in paragraph 74 and the date should be 17 July and not 8 July.

Q Okay, if we could move forward, please, to page 303. So you referred to paragraph 74, Mr Wright,

and I think what you said was that the reference there to 2019 should in fact-- sorry, to 8 July should in fact be to 17 July.

A That's correct.

Q Yes. Thank you, and with that correction, does the statement set out fully and truthfully your evidence on the matters that it contains?

A It does.

Q And is there anything else that you think needs to be changed or corrected?

A No.

Q Now, I understand from your statement that you are now retired. Is that correct?

A That's correct.

Q But prior to that, you were the director general of Health and Social Care in the Scottish Government?

A That's correct.

Q And that post also made you the chief executive of the NHS in Scotland?

A Yes.

Q And your statement explains that you retired from that post in, I think, July 2020?

A Yes, I became physically unwell in about April 2020, and I eventually retired in July 2020.

Q Okay, so should we understand from that that you were absent from work from the April and then formally retired in the July?

A That's correct, yes.

Q Your statement also explains that you had held that post from February 2019, first on an interim basis and then on a permanent basis?

A That's correct.

Q And prior to that, you had held chief executive posts at various Scottish health boards and trusts?

A That's correct.

Q And your career also includes senior management roles at children's hospitals?

A Yes.

Q And could you just tell us which children's hospitals you worked at and in which posts?

A Right, I had two spells at the Royal Hospital for Sick Children in Edinburgh. The first one was in the late 1980s, where I was there for two years as what was called the operational services manager at the time. I then moved to the Hospital for Sick Children at Great Ormond Street in London where I worked for, I think, three years, and I was the hospital administrator for the Hospital for Sick Children at Great Ormond Street, and that gave me a tremendous insight into

high quality child healthcare and high quality child hospital services. I then returned to Lothian as the unit general manager for the Royal Hospital for Sick Children and for the Edinburgh Child Health Services, and I was responsible for taking that into NHS trust status and I became the chief executive of that trust until the time that that trust was dissolved, I think, in 1999.

Q Okay, thank you. Now, these are simply highlights in what your CV reveals to have been a long and successful career in healthcare, and you record in your CV some involvement with projects to construct or refurbish healthcare facilities.

A Yes.

Q Can you just give us an indication of your role in relation to those projects, their scale and complexity relative to the project to build the RHCYP DCN?

A Yes. So, when I was at the Hospital for Sick Children at Great Ormond Street, they just had the Wishing Well Appeal and they were doing major construction works to rebuild Great Ormond Street Hospital on the site of an existing hospital while it was still operating. So lots of decanting work, lots of old buildings with things wrong that would cause infections, lots of infection control measures had to be taken, negotiation with contractors and so forth. So I was intimately involved in that work and particularly keeping the hospital running while that work was being undertaken.

I then came back to the Sick Children's Hospital as I described, and at that time there'd just been a fundraising appeal in Edinburgh and money had been raised by the public actually to build new operating theatres and intensive care unit and new surgical wards. I think it's very interesting that 25 years or so further down the line, you know, they are not now fit for purpose, but at the time and compared to what they had before, it had been a huge step forward to get a paediatric intensive care unit properly operating at the Sick Children's Hospital.

Q Okay.

A And then in Dumfries and Galloway, I oversaw the private finance initiative to build what was then the new maternity hospital, and I could describe others as well but those are some of the things I've done.

Q Okay, and the project that you described there at Great Ormond Street, whilst that was going on at the same site, from the way you

put it, it sounded rather more than a refurbishment and actually more or less a new build on an existing site?

A It was a massive capital project which required demolition of existing buildings. I remember we had to physically move the chapel of the Great Ormond Street Hospital from one place to another on stilts, and then rebuilding a new hospital right in the middle of an operating hospital. So it was extremely complex, and I got good insights into relationships with contractors, subcontractors, architects, design teams and so forth.

Q And on those projects, were you the senior executive person in charge of it from the health board or health trust point of view?

A No, I wasn't. I was the hospital administrator there. So there was a chief executive of the hospital, there was a project team, there was a project director, and they did not report to me, but I was part of that and my main role was to keep the hospital running while all of these works took place. So I observed them, I played into the processes, advocating for patient care while all of this work was going on.

Q Okay, so should we understand from that that your functions in relation to those projects was more a case of keeping the hospital services running as well as they could against the disruptive background of a construction project?

A Yes, that's correct.

Q Yes. Okay. Just given your experience in that regard, what challenges would you say that a health board or a health trust face when called upon to deliver a major infrastructure project?

A I think it's important to get the right people in the right places with the right skills. So I think everything from the most senior management through making sure that the governance is working well, making sure that there are lines of reporting through and I think, critically, that there are checks and balances within the system and that there is independent challenge to what is going on that can be brought to the attention of the people who are running the project. So these things that I think Tim Davidson described are hugely complex, and I think interrelating with design teams, contractors, subcontractors and all of those contractual relationships needs a huge amount of effort and expertise, but also to make sure that the clinical view is playing into that really very, you know, right at the centre of it. That's

what-- To me, that's what should drive it.

Q Okay, and one of the themes that has emerged from evidence before the Inquiry is that often the people in a health board, confronted with this challenge, may not have done it before and so the question arises when you are making sure you are trying to get the right people in the right place at the right time, how does a health board face up to that when perhaps its senior management and operational people have not come across this sort of challenge before?

A Yes, and I think it's been pointed out in the Inquiry that we have boards of different sizes in Scotland. So a board like Lothian and a board like Glasgow will have well-established capital planning functions, well-established Estates and Facilities management and senior clinicians who are used to operating at that level. Some of our smaller boards in Scotland, this may very well be a kind of once in a career time when they're-- when they're doing that, and I think the important thing is to take advice, and certainly in my time I would always go to organisations like Health Facilities Scotland/Health Protection Scotland to make sure that we've got the right people with the right skills and we've got the right sort of oversight of the project.

Q Okay. So that is the question of the skills, but what about the question of workloads? One imagines that before any construction project comes on the agenda, everybody in the health board is pretty fully occupied with running the health services themselves. How do the health boards face up to that challenge of trying to fit that into otherwise busy schedules?

A Well, I think that's where the business case comes in and I think the capacity to lead the project needs to be defined within the business case and clearly articulated. So having the capacity to do that and making sure that the governance processes of the Board are suitably modified to make sure that these projects are being correctly overseen, and I think it is a challenge for a chief executive and an executive team to be keeping the day job running, if you like, of delivering services every day for hundreds of thousands of people and having big capital projects to deal with. So I think making sure that executives have got the supports in place, that they're clearly articulated in the business plan I think is essential.

Q Okay, and we perhaps live in a world where-- or a world of increasing complexity where things just get more difficult and more technical and, you know, advances are made in scientific knowledge around healthcare and that kind of thing. Does there come a point where a healthcare construction project becomes so large and so complicated that it is really too much to expect a health board to deliver it?

A No, I wouldn't say that because the statutory function of a health board is to run the health services within that area and to take responsibility for major capital projects and, you know, there might be an area for the Inquiry about, should that change in the future? My sense is that if we have statutory organisations set up to do this that are close to the clinical interface, close to the patient interface, then that's where they need to sit.

I think making sure that there is the capacity built in to support the executives and that is really the essential thing, and I think making sure that the external checks and balances are in place where people who really know this stuff are there challenging the people who are doing it, and there's a constant sense of challenge. I think Ms Freeman said in her evidence that governance is a verb. I think it's a very active thing that needs very active challenge and it needs checks and balances there, and I think you need to design the system that's got those checks and balances.

Q Okay, and you explained that one of the projects you worked on, the Dumfries and Galloway one, was procured in a PFI structure. Does a PFI structure bring different challenges for a health board?

A Yes, it does, both in terms of the legals and the negotiation, and I remember well the very long legal discussions we had making sure that the specification was correct, and then once we got that over the line, making sure that the building was delivered on time, and it could be commissioned, and it was fit for purpose. So it does-- it certainly does add a complexity to it than if it was a capitally funded project.

Q Okay. As we have covered, you were of course the director general of health and social care in the Scottish Government. Could you please just give us an overview of what that role entailed?

A Right, well, the director general is appointed by and reports to the Permanent Secretary. In my time I

think there were six director general covering all of the functions of Scottish Government, and the director general appointed is expected to play a corporate government-wide role in running the whole of the Civil Service and making sure that the aspirations of the elected government in totality are met. The role of director general for health and social care, I think, is particularly complex in that, unlike other DG roles, it has an operational responsibility for running the National Health Service in Scotland like other DGs, but I was the accountable officer for the 14 billion or so of public expenditure.

So there's a strategic role, there's a policy role, there's a very strong role working with and supporting the Cabinet Secretary for health. I had a team of directors – I think there were nine directors in my time – all of whom have direct access to ministers. So it's not all mediated through the DG, but one of the jobs of the DG is to make sure that that team is functioning well and that ministers are getting the advice that they need, when they need it, and that issues within the NHS right the way across Scotland are being anticipated, spotted, and that action is being taken in order to address challenges that inevitably arise on a daily basis.

Q One of the points you mentioned there was that unlike the other directors general, the director general of health and social care had that operational function, and is this why there is the dual title for that post, the director general and also the chief executive of the NHS in Scotland?

A Yes, and it's to give the sense that the director general is the chief of the executives in the National Health Service in Scotland and the accountable officer. So there's a direct accountable officer line of reporting from the 22 accountable officers that were there when I was there through to the director general and that I have to sign off, and I'm personally accountable to Parliament for that public expenditure.

Q Okay, and you referred to the Cabinet Secretary for health and sport. Just in general terms, how does she interact with you and the other directors under you?

A She interacted regularly. So there would be a pattern to the week, as it were. So every week after cabinet, myself and all of the directors would meet with the Cabinet Secretary and other ministers, and she would give feedback from cabinet and we would brief the Cabinet Secretary on

current issues and sometimes talk about policy and where we needed to get to. So that was a regular weekly occurrence; and the second fixed point in the week, if you like, was my chairing of the Health and Social Care Management Board, where I bring together all of my direct reports, but also some directors from other parts of government that have got a role in health and social care.

Quite often – I would say quite regularly – the Cabinet Secretary and her ministers would attend that for discussions about where we want to get to with the NHS and social care in Scotland, the kind of actions that we need to take, and she was very keen indeed to listen to the views and the input from her directors and we would have very, I think, creative discussions at those sessions. So these were fixed points. I met with the Cabinet Secretary on a one-to-one basis as well, on a weekly basis, and we spoke regularly on the phone.

Q Okay, and throughout your time as the director general, was it Ms Freeman who was the Cabinet Secretary throughout that whole period?

A Yes, she was.

Q And I appreciate this is probably a slightly unfair or difficult question, but what sort of issues were elevated to the stage of the Cabinet Secretary in relation to the health service?

A Well, I think every single health board in Scotland has got a range of issues. So sometimes they're performance issues, sometimes they're public health issues. So one of the issues that Ms Freeman and I particularly spent time on together was NHS Highland where there was all of the work on bullying and harassment and how to reach a resolution there, and we've certainly visited that together.

So those sorts of issues, and it really could be anything that was going on. Ms Freeman relied on her directors telling her what was going on, giving her advance notice of issues, and even if we didn't have a solution, she'd rather know about them and we could have a discussion about it. So we got into a way of working where I think directors were very comfortable sharing issues with her. It would be an interactive discussion and ministers were very able to take appropriate decisions quickly.

Q And does the nature and content of that briefing of a cabinet secretary, does that vary from cabinet secretary to cabinet secretary and

from director to director? Do you have to sort of develop a way of working?

A Yes. I can't speak for other cabinet secretaries, but I think the way of working in health and social care had to be different because of the operational responsibility for the NHS in Scotland. One of the things I learned going into government, which you don't really see so much when you're outside government, is just a level of democratic scrutiny that ministers are under, whether it's parliamentary questions, parliamentary debates, appearances at health and sport committee, appearances at audit committee. Given that health and social care in my time took up about a third of the whole of the Scottish budget, that democratic scrutiny is absolutely appropriate, but, you know, ministers need to be briefed on what's going on, and she rightly expected her directors to tell her what was going on and what we intended to-- or what we planned to do about it.

Q Okay, and so should we understand from that issue of democratic scrutiny that issues that are out in the public domain are likely to be ones which will be elevated up to the Cabinet Secretary's knowledge, so that she is able to deal with questions about them and so on?

A Yes, absolutely, and I think part of the role of the team for civil servants is to make sure that ministers are prepared, that they're not-- they don't find out about something through a press interview or a question to Parliament. So if we knew there was an issue we would tell her about it and we'd tell her what was going on and try and give her assurance that the Board was onto it and dealing with it; but it really struck me, going into government, just that weight of parliamentary scrutiny, which you don't really see when you're outside government.

Q Okay, and that perhaps leads us on to a related question, which is, just to demarcate the role of the Scottish Government in relation to the NHS and the role of the health boards in relation to the NHS, could you give us your view of that?

A Okay. So, I've worked in health boards in Scotland for 25 years or so and I've been a chief executive of, I think, nine different statutory bodies in Scotland. I think I've got that right. So I think when you're working in a board and you're appointed by your board to be the chief executive or an executive director, you've got your chairman, you've got your non-executives, you've got your local

representatives, you've got your staff side, you've got your BMA, you've got the RCN, you've got all of that, and you're trying to deliver services to a local population, that's a really important thing. I think some of the skills of a good chief executive is to learn how to manage into government as well. So making sure that government is kept fully informed, and even when there are problems it's better to let government know that there are problems rather than government finding out in another way.

So, statutorily, boards are set up in primary legislation; they have a range of functions; they are the statutory bodies; they have responsibility for running health and social care services; and they are empowered by government to do that. So the role of government is one of setting policy, making sure that the system is performing as it should be. I think it is about holding to account.

So, all of the cabinet secretaries have annual reviews with different health boards. I think we've developed a system of mid-year reviews, so that there's a regular dialogue between the responsible elected politician and the chairman and the chief executive of the board with the director general and other officials in the room about holding the system to account, learning what the challenges are, putting in help where that was needed.

So, I remember my time in Grampian where we were having real difficulties with our mental health services and the government was able to source help from another part of the country to come and give us some expertise that really helped us. So it's not all about performance management, it's also about making sure that help is put in when it's needed with the objective of getting better services for people at the end of it. So there is a distinct difference in the board as a statutory authority, I don't think we would seek to undermine, certainly in my time in government.

Q Okay. One of the issues you raised there was the need sometimes for additional support from central government to the health boards, and the Inquiry has heard evidence about the escalation framework which the government had. Was that always the framework for decisions about government intervention in the work of health boards?

A Well, I think it's one of them. So, I think the Inquiry has heard evidence from John Connaghan about

his role as chief performance officer. So John and his team were constantly working with the boards to see where they were on performance, what help they needed, if resources were available for, say, waiting lists or service improvements. We would go through John's good officers and have discussions with boards and make sure that those funds were applied. I think that-- Sorry.

THE CHAIR: No, no. I am just listening.

A So the ladder of escalation, I think, is part of that, and I think John described in his evidence that that's part of the role of the director general and the accountable officer, and that all boards will be somewhere on the level of escalation. The intention is to get them as low as possible on that ladder of escalation. The intention is to have a process that is clear and transparent as to why boards are on the ladder of escalation, and when they are on the ladder of escalation, to make sure that tangible support is provided.

So at the very highest levels, that can mean, as we did with Level 4 and Mary Morgan, actually putting somebody in to report to government to add extra weight and leadership to a particular topic. Or it can mean, lower down on the ladders of escalation, to say, "We're going to monitor the performance more closely and we're going to put additional funds in for this, this and this," and I think that gives a transparency, because other boards are looking to say, "Well, how's that board got money and we haven't got money?", and I think doing that through the ladder of escalation is a much more transparent way of doing it.

MR MCCLELLAND: Yes. You have used the word "transparency" there, and for the Inquiry, trying to understand how relations work between health boards and central government, one can look down the framework and the different stages on it and understand the points at which government may get involved and the reasons why, but did I understand from your earlier answer that there is more to it when one is looking at the relationship between governments and health boards? What other routes and means are there for government involvement in health boards?

A Yes, and I think I made reference in my statement to the fact there are many networks within the NHS in Scotland. So, for example, the chief medical officer would regularly meet all of the medical directors in the NHS. The chief nursing officer would

do the same. The head of people, the head of HR within government would do the same with all the directors of personnel and so forth.

I think Alan Morrison has described the networks with the Strategic Facilities Group and how NSS help us with that. So there's a lot of networks going in. I personally would meet on a monthly basis with all of the Board chief executives, and they would have a private meeting and talk about what they wanted to talk to me and officials about, and the senior officials from Scottish Government would meet with all of the Board chief executives on a monthly basis and have discussion about-- and these discussions were minuted, have discussion about government policy, the challenges the boards were facing.

So there was multiple intelligence coming into government about just how individual boards were doing, and I think the relationship was-- you know, it's a different statutory function, but I think the relationship I thought was close, it was positive, it was collaborative. It was sometimes difficult, and I would always encourage a board chief executive that if they had an issue, to pick up the phone, and many did and would. So I think we tried through multiple channels to keep close to boards to understand what they were doing, so that (a) we could support them and (b) that we could make sure that ministers weren't blindsided by things that happened.

Q One of the bodies within government that you referred to earlier on was the Health and Social Care Management Board. Was that a body that you chaired as the director general?

A I did.

Q Yes, and who else was represented on that board?

A Well, all of the directors in the Health and Social Care director family, so the chief medical officer would be there, the chief nursing officer would be there, John Connaghan as the chief performance officer would be there, the head of-- the director of HR would be there, the director of health and social care integration would be there, the director of mental health would be there, and the director of finance would be there. So they-- We would all meet formally on a minuted weekly meeting which was supported by my private office, and we would often have directors from other parts of government coming in, where things like the chief social work officer would sometimes come in, somebody who's responsible for

housing policy in Scotland would come in. I think I've described somewhere my role in the Health and Justice Collaborative where we're trying to bring health and justice together to, you know, work with the police and local communities to look at some of those issues. So-- But basically that, that's what it was. It was a formal governance meeting of the Civil Service that I chaired with my directors.

Q Okay, and it was that body, the Health and Social Care Management Board, which took decisions about the escalation framework. Is that correct?

A Correct.

Q Yes. Just so we can try and understand, in what circumstances would the governmental involvement with health boards follow that more formal or transparent structure, and which issues are left to the sort of softer – if I can put it that way – connections between health boards and government?

A The priority was always that if we could avoid it, we didn't want to put anybody on the ladder of escalation. So, I would rely on my directors, particularly John, but also chief medical officer, chief nursing officer, to be working with boards to sort out problems, and particularly, improve performance. And there's always been a lot of public attention on access, so A&E access, outpatient waiting, inpatient waiting, and we monitored these things very, very closely.

I think if we felt that the board was really getting to the stage of really struggling with this, then there was a sense of, actually, we need to monitor this more carefully, and we need to put some more resource in. And by resource, it's not just money, it's sometimes expertise, it's sometimes bringing in somebody from another board who's had some success there. So, when it got more serious and we kind of felt this board needs more help, then that would be put on the-- a paper would come to the Health and Social Care Management Board with a recommendation, and all of the directors would be there to discuss it, and that would be my decision as director general. I'm very happy to describe the process around the Level 3 escalation if that would help the Inquiry. That's the background to it.

Q Yes, we will come on to the project-specific issues just shortly. You are talking there in terms of transparency and support in the context of the framework. Do you

recognise that there is sometimes a perception amongst the public, and perhaps even health boards themselves, that escalation is a punitive step for poor performance?

A Yes, I do, and having been on the other end of it, I absolutely get that because if you're in a board, you're working really hard, you've got your team, you've got your chair, you've got your non-executives, you've got your local community, and to be put on the ladder of escalation, I think, you know, for a leader of a healthcare system is actually a really challenging thing. So I understand that. You'll have seen from my CV, I was asked by government to go into a number of boards that have had performance challenges and I've met with those teams. So, you know, when I was asked to go up to the Western Isles to help with them, you can see how boards and people will react to this happening, so you want to avoid that if at all possible. So I do understand that.

Q Okay. Separately from the Health and Social Care Management Board, the Inquiry has heard evidence about the Capital Investment Group within the Scottish Government, and as I understand it, it was responsible for the sign-off at government-level for capital projects. Did you as the director general have any role in relation to the CIG?

A Yes, in that I was the accountable officer and responsible for its work. So, the capital planning and the capital strategy for Scotland was under the leadership of the director of finance and Alan Morrison, who was the deputy director, was leading on a lot of that day-to-day work. I think other witnesses have described how that Capital Investment Group works and, again, I'd need to go back to my notes but the director general and the Health and Social Care Management Board, to my memory, would be signing off things as they came through.

Q Okay. Now, in your witness statement, paragraphs 19 to 26, you discuss events that were underway at the time you took up the post as director general. I think at that stage it was on the interim basis. So this is early 2019.

A Yes.

Q Just by way of context for this, and you may have seen this letter in the papers that you have had access to, but on 25 January 2019, your predecessor in that role, Paul Gray, sent a letter to health boards.

A Yes.

Q If we can just bring that up, it is at bundle 4, page 8. Is that a letter you recognise, Mr Wright?

A Yes, I do, yes.

Q So, if we just look at it. It is sent out to NHS chief executives, and it is from Paul Gray, the then director general of Health and Social Care, 25 January 2019, and the heading is, "Queen Elizabeth University Hospital", and he says:

> "Following my call with you on Tuesday 22 January about the ongoing incident at the Queen Elizabeth University Hospital, I said I would write to you with a set of actions. [And then he goes on] While the cause of cryptococcus infections and QEUH is not fully understood at present, and we continue to gather further intelligence on the situation […] there are a number of controls which I would like you to confirm are in place and working effectively…"

And there is a list of bullet points there, and the final one refers to inspection and maintenance in line with SHTM 03-01, which is the guidance for ventilation in healthcare premises. So do we see there that, in January, whilst information and knowledge was evolving, the matter of hospital ventilation was on the radar screen of the Scottish Government, if I can put it that way?

A Yes, and in a very serious way. I think one of the interesting things about that letter is the first sentence where he says, "Following my call to you," and it was not uncommon in Paul Gray's time, nor indeed my time, if there were a set of issues arising somewhere, we would get the accountable officers on the phone in a teleconference with senior government officials in the room. Now, I don't know the detail of that call, but I imagine that that's what it would be, and I would imagine that there would have been a discussion about what was arising, the seriousness of it, the views of the Cabinet Secretary about it, and what action was required. So I think there would be a strong expectation for action arising from it.

So, I think two things are significant. One, there appears to have been a phone call and, secondly, this came from the director general. I think directors general tend to be very careful on the occasions that they write to the service. So when a letter does come out, it's actually, "This is serious."

Q Okay. Now, you quite fairly pointed out that you did not send

the letter and, in fact, you were not in post at the time obviously, but once you came into post, was this an issue which you were aware of?

A Yes, it is.

Q What were the concerns around the Queen Elizabeth Hospital at that time, insofar as you understood them on arrival in your post?

A There was a very significant amount of concern about incidents that were being reported, incident-- the patient safety issues that were arising. It wasn't clear what the underlying cause of these issues were. There was a lot of conversation going on, and I know that the Cabinet Secretary, the chief nursing officer, the chief medical officer were intimately engaged in this, and I think this was a mechanism to say to the wider service, "Look, we have issues here. We need you to positively assure yourselves that these things are understood and under control."

Q To what extent around this time, at least as you understood it, was ventilation thought to be relevant to the problems?

A At the Queen Elizabeth?

Q Yes.

A I couldn't put a time on that, but it's clear from this that it was before this letter was written.

Q Okay. So, that letter is 25 January 2019, and on 22 February 2019, NHS Lothian and IHSL, the project company, entered into a contract called Settlement Agreement 1, and this is a contract which documented technical solutions to matters about which the parties up until that point had disagreed, and amongst those were agreed solution for ventilation in patient areas of the hospital. To what extent were you aware of Settlement Agreement 1 at that time?

A I was informed of it. So, when I came into post, I received briefing on all of the capital projects within Scotland, and I was made aware of the Settlement Agreement and some of the challenges that had occurred that brought the Settlement Agreement around, and the programme of work, both to finish the building of the hospital, and to do the commissioning of the hospital.

Q Were you made aware of it before it was signed?

A I couldn't-- I don't know. I think the approval from government had come sometime previously to that.

Q Were you aware that it involved technical solutions which, amongst other things, resolved disagreements about the ventilation?

A Not in that level of detail, no.

Q At what level of detail were you aware of what it was doing?

A I was aware in the briefing that I received that the work had gone in, the Settlement Agreement had been negotiated, it had been signed off by Scottish Government in terms of the funding, and that Lothian were proceeding to sign off and implement that Settlement Agreement. So the detail of the technical fixes, I would not be aware of.

Q Yes. I mean, one understands that given the level of responsibilities and breadth of responsibilities at the director general level, you might not have seen the sort of very detailed technical solutions but so far as you are aware, did the Scottish Government seek any assurance at that time about whether or not those technical solutions were appropriate ones?

A I'm not aware that the Scottish Government did.

Q Was the approach within the Scottish Government in relation to Settlement Agreement 1 simply to assume that the Health Board would get those sorts of decisions right?

A I wouldn't say it would be to simply assume. I think the responsibility to get those decisions right firmly lay with the Health Board.

Q Okay. So, would it be consistent with the way in which decisions were made about capital projects at the time that the Scottish Government would not seek assurance about whether those technical solutions were correct?

A Yes. Certainly when I went into government, the role of the Scottish Government vis-à-vis the capital program was very much focused around the strategic cases and the business cases coming through, the sign-off of the business cases, the allocation of the capital, and making sure that those programs were running to time and to budget, and that we got feedback from that. The statutory body for actually running those programs and making sure that all of those things were in place was clearly the responsibility of the Health Board.

Q Okay, so just to be clear about that, would you have seen it as consistent with the Scottish Government's role in capital projects up to that time that the Scottish Government, even though aware of Settlement Agreement 1 and even though aware of possible issues with

ventilation at the Glasgow hospital, that it would not be part of the government's role to seek assurance about the appropriateness of the technical solutions?

A At that time, I think, yes, and I think that is reflected in the size of the capital planning function within Scottish Government. Alan Morrison had, you know, not a large team overseeing this, and I know the Inquiry's asked other witnesses about levels of, you know, how many engineers in Health Facilities Scotland, for example. I mean, there were no engineers working within the Scottish Government. So, it was a strategic role looking at the overall capital plan for Scotland, and it put reliance on the boards to have done the work and to ask us to approve the finance and the strategic case for that work.

I think, moving forward, how that work gets checked, I don't think that that is a role for Scottish Government, but I think the proposals for NHS Assure and the key stage reviews and making sure that experts who are external to the Board can go in and challenge that work with a deep knowledge base, I think that's the level of cross-check that we need, but when I went into government that did not exist.

Q Okay, and what would you have seen as the purpose of the Scottish Government being told about Settlement Agreement 1?

A Well, the Scottish Government, I believe, were told in the middle of the previous year about negotiations going on with their contractors, and it certainly required an input of public money. So there was a reliance on the Board to do those negotiations and to come to the Scottish Government to say, "This is where we've got to and this is the resource we need in order to get this hospital open."

Q Okay, and so was the Scottish Government's approval required in order to release those funds for Settlement Agreement 1?

A That is my understanding, given that all of that had happened, you know, some considerable time before I got into government, so I'm saying what I believed to be the case.

Q Okay. I think your answer has been perfectly clear about what was the division of responsibility between government and health boards at that time. Would it have been possible for the government to ask for HFS, for example, or HPS to have a look at the technical solutions

before approving the payments for Settlement Agreement 1?

A It would have been possible, and that had a policy implication because, if we're doing it for Lothian, what are we doing for Grampian? What are we doing for Glasgow? What are we doing for Orkney, and all of the other hospital building projects? So there is a policy decision behind that that says, "Actually, we need to put capacity into Health Facilities Scotland, Health Protection Scotland, in order to do this work." The old Common Services Agency Central Building Division used to have a significant amount of capacity to do some of this work in the past, and I think with the advent of NHS trusts and the advent of boards, that was pretty quickly wound down and it became an advisory function, and that all of the responsibility for leading and delivering capital projects in Scotland very much was with the boards, and they were accountable to government. You will see from my evidence that when this problem with ventilation was highlighted, my first questions were, "What's the involvement of HPS and HFS in this? Have they been involved? Have the Board actually called them in?", but that was the position as of February 2019----

Q Okay, so----

A -- is my understanding.

Q So, just if I can try and repeat back what I have understood from that, and please do not let me put words in your mouth, but I would like to know if this is an accurate way of understanding it, that even if somebody in the Scottish Government had thought it was a good idea to ask HFS to review Settlement Agreement 1, it would not be as simple as thinking whether that was a good idea for that particular project? You would also have to have in mind what implications that would have for the relationship between government and health boards for other projects. Is that a fair way of putting it?

A That would be my sense of it, yes.

Q Yes, okay. So, a few months after Settlement Agreement 1 was signed on 2 July 2019 it was brought to your attention that the critical care ventilation in the RHCYP/DCN might be non-compliant with the SHTM guidance, and is it correct that this was something that NHS Lothian had themselves identified through the engagement of a validation engineer?

A Yes.

Q And it was NHS Lothian which had reported the matter----

A Yes.

Q -- to government? So, when this came to your attention, you decided that it had to be reported immediately to the Cabinet Secretary?

A Yes.

Q And can you just explain why?

A Okay. So, we had a planned phone call with the chief exec of Lothian Health, and I think the chair was there as well. John Connaghan was with me. So we took the call and Lothian told us that a major problem had been discovered, that they had found, very recently, that the air changes would only do 4, and they were designed to do 10. So that seemed to John and I to be a very significant challenge, what, three days out before people were due to move into the new hospital.

So, you know, if you wish, I can describe my reaction to that, but the actions I took were to say, "We need to understand this, and we need to understand it quickly." So I would have – given that the Cabinet Secretary's office was 30 yards from mine – gone round to her private office and told her private office staff that this had happened and to immediately mobilise the Civil Service to find out what is going on here and, "Let's get a written briefing to the Cabinet Secretary by close of play today as quickly as we can possibly do it."

I think, again, using the good officers of John Connaghan, we stood up the Health Resilience Function, and officers of the chief medical officer, the chief nursing officer, the head of health workforce were involved, speaking to their counterparts in NHS Lothian, finding out what it was that was actually going on here, and how serious this problem was, so that we could brief the Cabinet Secretary, so that she could decide what she needed to do about it.

Q Yes. I mean, the answer to this question may be a little bit sort of self-explanatory, but what was it about the issue which made it clear to you this had to be brought to her attention?

A The magnitude of it, in that Lothian had specified a Paediatric Intensive Care Unit with 10 air changes an hour, which met the national standards and guidance, and I know there is a discussion about the meaning of those standards and guidance. Clinicians were expecting that. Infection control teams were expecting that. Patients were

expecting that. The patient population being able to be treated in that was expecting that. So, not to have that in place three days out seemed to me to be a very major challenge, and then to say, "Well, how do you do remediation here if remediation is required? Will we need a decant of paediatric intensive care? Where do you decant them to? How do you safely decant them while keeping operating theatres running?"

The difficulty about taking out national paediatric intensive care capacity, which was severely challenged at the time, I think was another factor in all of that. So it just seemed to me that there was a whole set of practical implications for this that the Cabinet Secretary needed to get around quickly, and we needed to make pretty fast decisions about what actually was going to happen.

Q Okay, and you referred in your answer a moment ago to the Health Resilience Unit within the Scottish Government being activated. I think we can see from the papers that it was in operation between about 2 July and 18 July. Can you just explain what that unit is? For example, is it a standing feature of government, or is it something that is established in response to emergencies as and when they arise?

A It's a standing capacity that we have within the DG Health within government. It's not a large unit but there are some very experienced colleagues who work there, and they report it through to John Connaghan as the chief performance officer. So, if there was a, you know, critical emergency situation somewhere within the NHS in Scotland, they could give us capacity as to how to manage that, how to manage the flows of information, how to manage the communications around that, and making sure ministers got what they needed when they needed it. So it was a good resource to have, and I'm very grateful to John and for them to respond to it.

Q I mean, do we understand from that that it is essentially a way of applying an administrative resource to gather information, process it, make sure that the government has the proper information for making decisions?

A Yeah, so that ministers could make decisions, but also we could do all the other things in government that we need to do. So, for example, informing the principal accountable office, i.e. the permanent secretary, of all of this, informing the

director of finance for the whole of Scottish-- so DG Exchequer needed to be informed, informing the chief financial officer for the Scottish Government.

So a whole set of things in government that need to be coordinated. Briefings needed to be provided, not just for our ministers but all ministers, so that if they were asked questions in a public environment, that they could respond to it. It's a whole series of things that need to happen, and this was a really good resource to help us pull that work together.

Q Okay, and as I said a moment ago, it seems to have been stood down after about two weeks. Can you just explain, you know, the decision-making standing it up and setting it down and the reasons behind that?

A Yes. I believe John Connaghan, whose judgment in these situations I trust absolutely, I think he stood them up and stood them down, but by the time they were stood down, the Cabinet Secretary had made the decision and we'd put in place the escalation, which led to (a) money going into the board to help with the performance issues, and I know we'll be talking about that, but also the establishment of the Oversight Board that brought to bear the chief medical officer, the chief nursing officer, Christine Mclaughlin, working with the medical director, the nursing director, Susan Goldsmith, within NHS Lothian. So we put that capacity in on both of those fronts. So by the time that we got to that point, that capacity had already been deployed.

Q Okay. If we could bring up on screen, please, bundle 7, volume 1, page 37.

THE CHAIR: Thank you.

MR MCCLELLAND: We see here that these are emails from Alan Morrison, and you are one of the recipients, I think perhaps the main recipient. Oh, no, sorry. Yes, you are a copy recipient. So, if you just look at the bottom email, the 2 July 2019, 4.53 p.m., we see that Alan Morrison is saying that he has attached a short briefing regarding an emerging issue with the new Edinburgh Children's Hospital.

Now, if we just scroll down to the next page, please.

A Yes.

Q This we take to be the briefing document, headed up with the name of the hospital and then the situation, the briefing reads:

"Yesterday evening (1/7/2019) NHS Lothian was

informed that the rate of air change per hour in the paediatric critical care rooms of the new hospital does not meet the recommended national guidance of 10 air changes per hour. When testing the ventilation in critical care, our commissioning engineers, IOM, found that air was being replaced in four four-bedded rooms and five single rooms at a rate of four times per hour."

A Yes.

Q So that particular-- You see how it has been described in that briefing document to you. Was this the sort of long and short of it, as you understood it, in the government?

A As we understood it at that time, yes, that was the presenting issue.

Q Yes, and was it-- Over the time that you were involved, was it always presented as, beyond argument, a failure to meet the requirements of guidance? Or was there ever any sense that it was more nuanced than that?

A I think there is nuance to it in terms of pressure rates, but I don't think there was nuance to it in terms of the air change rate, in that this had been specified by Lothian, it had been specified by their clinicians, it had been supported by intensive care and this is what-- you know, this is what everyone had thought they'd paid for and was going to be delivered. The point I made earlier about the hospital being built in 1895, it's still going, the hospital being completely refurbished in the 1990s, why wouldn't you want to build it to the best modern standards? That was the specification, that's what we set out to do, that's what we expected, that's what clinicians expected and why wouldn't you want to do that?

If you did do that, and I was conscious of Tracey Gillies' evidence on this about risk being on a continuum and it being a function of the mechanical systems, the building systems you've got in place and also the practices. What we wouldn't know that if you had a lower air change rate, what difference that would make to the types of patients that could be treated there. Secondly, as standards moved on, the job you'd need to do to get that to where you need it to be, would be even bigger. So I think there's a strong sense, and I don't think anybody said to me at the time, "Let's just go with four because it's better than what we've got in the Sick Kids."

Q Yes.

A "We've actually set 10, and we've set 10 for a hospital that's going to last us at least 25 years and it's going to be one of the best and the safest in the whole of the NHS in Scotland."

Q Okay. You may have become aware that the designers, TÜV SÜD, Wallace Whittle, have an alternative interpretation of the guidance that, in actual fact, four air changes for these particular rooms was compatible with the guidance. That appears to have been their view at the time, and their designer has given evidence to the Inquiry that that remains his view now. Was that a perspective which reached decision-making at the Scottish Government level?

A Not to me. I can't say if it reached anybody else's level. I mean, I know there was a debate about four being better than nil, and I think it's much more nuanced than that, but I never heard a debate going about, "It shouldn't be 10."

Q Yes.

A And listening to the evidence that this Inquiry has had, and you will know this much better than I, I'm not aware of any body of evidence that says that, "We shouldn't be going for 10," but, you know, you will know better than I.

Q Okay. If we go then, please, to bundle 7, volume 1, page 48. This is an email from Alan Morrison to various recipients. I think-- Yes, I think you are one of the recipients, not by name but by office at DG Health and Social Care.

A Yes.

Q So this is 3 July 2019 just after noon, and as we see from the opening paragraph of the email, this is an email to you and John Connaghan from Alan Morrison----

A Yes.

Q -- summarising the outputs of a meeting which had taken place with HFS, HPS and Tim Davison from NHS Lothian, and if we just scroll down the page a little bit, we can see two blocks of bullet points. The first one is a list of main risks which have been identified, and then the second one is a list of unknown factors.

A Yes.

Q We see that the main risks, the very first one of those that has already been identified is that there were major concerns about the "risk of doing the permanent solution with patients in situ." So that appears to be recognition that if you move patients in and then do the work, that is a risky thing to do. If we go down to

the list of unknown factors, these include “The safety implications of running the facility with 4 air changes rather than 10,” and then two down from that:

> “The safety of the environment in which the patients are currently occupied, i.e. is the new facility with 4 air changes an hour still safer than the current site?”

A Yes.

Q I think that was the sort of considerations that you were alluding to a moment ago. So the existing design at this particular time, what had been built, was-- for the critical care rooms, was four air changes an hour and balanced pressure, and the pressure had been chosen by NHS Lothian clinicians for recognised clinical reasons, so that they could cohort infectious children together without the risk of spreading the infection further through the hospital. So far as you know, within the Scottish Government, was there any investigation into whether that arrangement of four air changes an hour and balanced pressure was actually unsafe, or was it simply assumed that non-compliance with the guidance was ipso facto unsafe?

A I wouldn’t necessarily categorise it between safe and unsafe. I think safety is a very nuanced thing that relies on the built environment, working practices, the patients there, so, you know, what you’re intending to do there, but I do recall there was a very clear view that 10 changes an hour was the standard. It was clinically appropriate, it was what people expected, it helped to future-proof the hospital for the-- in the long term. So I didn’t hear any discussion to say, “Actually, four changes is okay and we can work around it with pressures.” I’m not an expert on any of this, but least of all air changes and pressures, but my sense is from my chief executive experience that if you’ve got a standard in that HTM, and it’s been worked through with clinicians and you’ve specified it in the contract, actually, that’s what we want out of the contract.

Q Yes, and so would it follow from that that it just does not matter whether four air changes might, on a detailed risk assessment, be proved to be okay, what you wanted was 10?

A I mean, I wouldn’t say it’s irrelevant, but the point is we’re building a hospital for the next 25 years and we don’t want to get two/three years down the line or even

six months down the line and find, "Actually, this is causing infection that we didn't think was going to happen. Actually, there are some surgeons and some anaesthetists who say, 'I don't think I can treat this patient in this hospital. We better put them over to Glasgow,'" for example, as well as, "We're building a hospital for the next 25 years." So that, to me, was reasonably clear.

Q Okay, just so far as you were aware, there was never any suggestion that it might be worth doing a risk assessment about whether the four air changes was actually going to be sufficient?

A I think in the space of 48 hours doing a formal risk assessment with everyone who needed to be involved in that, that just was not going to happen in my view.

Q No, but even after the 48 hours, once-- the decision-making process about the remedial works carries on for longer than that.

A Yes, it does, but what we've set up through the escalation process is the Oversight Board. So we've got Scotland's chief medical officer, chief nursing officer, we've got Lothian's medical director, their nursing director, infection control people, we've got HPS and HFS there and that's the place to have that discussion, and to my knowledge that was not a solution that anybody, to my knowledge, was advocating was a reasonable way through it.

Q Okay. If we just look to the-- just return to the screen, we have got to Alan Morrison's email of 3 July, down at the bottom what he says is that:

> "Given the information available, the consensus was that, with unknown risks associated with moving patients and then modifying the ventilation of the building, combined with the 'believed safe' environment of the current facility, the safety of patients would be better served by delaying the move and modifying the ventilation in the new building, before moving patients."

A Yes.

Q So we see there that, you know, a day after the balloon goes up, there is already a consensus, including Tim Davison on the face of it, that moving patients in was not a good idea and that delay would be appropriate.

A Yes, and I, you know, fully believe that everyone who put their heads into this, put patient safety

absolutely in the middle. I've no doubt about that at all.

Q Okay, then if we move to bundle 7, volume 1, page 66, and if we just scroll up so we can see the text in the bottom email, please.

A Yes.

Q So, you know, we can see things are moving quickly. This is later in the afternoon of 3 July 2019, and it is from Tim Davison, the NHS Lothian Chief Executive, to you and to John Connaghan----

A Yes.

Q -- and what Mr Davison says is:

> "Malcolm and John, further to our previous briefings and our telephone conversations over the last couple of days, I have set out below a brief note of the issues we have considered and our conclusions and propositions for dealing with the ventilation problems in the new RHCYP/DCN building at the RIE. We believe the problem is capable of being resolved fully over a period of around four months. There are a number of options for how the solution can be arrived at and each carries a degree of risk and uncertainty."

He carries on:

> "It is worth reiterating that our guiding principle in dealing with this problem and all previous problems and delays associated with this building project has been to prioritise patient safety and only to commission services in the new building when we believed that it was fully fit for purpose."

So I think this is the point you made a moment ago that everybody involved in decision-making about this has patient safety at the core of what they are doing.

A And I've worked with Tim Davison over many years, and I would absolutely, totally accept that that's his view and belief. I've no doubt about that.

Q Okay. Then if we read on down through his email, just the bottom of the following paragraph about three or four lines from the bottom, just starting along at the right-hand side, he says:

> "NHS Lothian is investigating how this issue has arisen and how best to address it in collaboration with IHS Lothian and their supply chain and is taking a range of professional advice (including legal and technical advice and advice from

advisors in infection control, health and safety and facilities engineering.)"

And presumably that is exactly what you would expect of a chief executive presented with these circumstances?

A Yes, and I think Tim and the senior team in Lothian, as soon as they became aware of this issue, they mobilised resources within the Health Board, they held meetings, they got advisors there, they tried to work out what it is that's happened and what are the potential range of solutions and workarounds. I think they were working flat out.

Q Okay, and then the following paragraph, he says that:

"Over the last 48 hours we have considered four main options for dealing with the ventilation problem and a range of key senior staff have been consulted including clinical staff and clinical leaders, executive and senior managers, project team staff, capital planning staff, the board chair and colleagues in Scottish Government, HFS and HPS."

So we see there the breadth of consultation that is going on and then he sets out the options, and if we could just scroll over the page, please. Option one:

"Continue with the planned move of all services and attempt to deliver the permanent fix for the ventilation problem while the critical care unit remains occupied [and he says this option was not supported]."

Option two, "Continue with the planned move of all services and then decant critical care," and again, he says that that option was not supported.

A Yes.

Q If we scroll on down, option three was to "Defer moving in to the new building altogether," and he explains that:

"This option is not supported because the rephasing of the move of the critical care unit only really affects those services dealing with the sickest of paediatric patients… It does not materially impact on DCN services and ambulatory paediatric services and therefore there is no need to defer these elements of the move."

And then the fourth option to:

"…rephase the timing of the move into the building to allow a phased occupation over

the next few weeks and months." He says:

"This option was supported as the best option. It would allow the permanent optimum solution for the critical care ventilation issue to be implemented in an empty ward without clinical risk and with limited disruption to the other users of the building; it prevents the need for double moves including a decant; it would allow DCN services to move in as planned; and it would allow ambulatory paediatric services including outpatients, therapies, programmed investigations and day surgery to move in over the summer."

Then he says below, "We agreed the following immediate actions," and the first bullet:

"Develop a communications plan between [the Scottish Government] and [NHS Lothian]. [And then the third to] …clinically risk assess and plan the re-phased moves."

So, first of all, one of the actions that Mr Davison recognises there is the need for a communications plan. Was that something thing that you thought was important?

A Essential.

Q And can you just explain why?

A Well, given what had happened, there was a very wide audience who would need to be communicated with, principally, patients and families. So the immediate, urgent priority was to inform patients who were due to turn up at the new hospital that actually they need to go somewhere else. So patient communication, I think, was really important. I think staff communication was hugely important. I think public communication was important. I think elected representatives, be they local or national, were important. And then, also, this would attract very significant press attention, and we would also need to communicate with the likes of the auditor general and a range of other people. So communication was essential.

Q Okay, and the need for it to be a joint communication plan, again, perhaps obvious why, but----

A Yes, and given that the Cabinet Secretary took the decision, it certainly needed to be a joint communication plan, and the Cabinet Secretary needed to be sure that the communications going out were completely aligned with the decision

she had taken and the information she'd got. So that needed to be pulled together.

Q Yes, okay, and you explain in your statement that your key action on getting this email was to get it in front of the Cabinet Secretary before her meeting with advisers the next day, and you go on to describe a meeting with the Cabinet Secretary and her other ministerial advisers on 4 July 2019. Can you recall which advisers were in there?

A Broadly, I think I can. I think it included the deputy chief medical officer because I think the CMO was away. I think the chief nursing officer was on planned leave, as I think she's described. So the deputy chief nursing officer was in the room. John Connaghan was in the room as a chief performance officer. I'm sure we had health resilience colleagues with us. Alan Morrison was there, and I think the director of health workforce was in the room, and there may have been others in the room as well.

Q Okay, and as you said a moment ago, was it at this meeting that the Cabinet Secretary took the decision that the move could not go ahead?

A Yes.

Q And you say in your statement that the key concern at the meeting was once again patient safety, but you also say that there was an awareness of emerging issues at the Queen Elizabeth Hospital. Can you just expand on what those emerging issues were?

A Well, the emerging issues, as described in Paul Gray's note and the feedback from that-- I think there is a second note during the course of March whereby Health Facilities Scotland write out to all of the boards asking for assurance about a whole range of things. I can't tell you specifically what this specific information was current at the time that was fed into that meeting, but I can also say that there were indications coming through to ask the question, "Is this hospital in totality ready for occupation? Have all of the checks been carried out? How many theatres are we going to get on day one and is it a safe environment to move patients into?"

I think as time goes on, some of those issues that were in there come through and I think, for me, confirmed that that was a very appropriate decision that the Cabinet Secretary took. But given that the chief medical officer's office, the chief nursing

officer's office and others were directly communicating with colleagues in the Board – and as I think Tim Davidson himself said in the evidence, you know, options three and four were actually coming together – there was a real sense of, "We can't have this going ahead this Friday, and whether it's a halt or a pause or a delay, whatever we call it, we're just not going to do this, this Friday. We're going to get to the bottom of it. We're going to put in the support team and work the issues through and only open the hospital when it is fully ready to be opened."

Q Yes, but just returning to this question of the emerging issues at the Queen Elizabeth Hospital, those are issues arising in the context of a particular health board, and the immediate decision concerns a different health board. What was it about the issues at the Queen Elizabeth that were thought to have a bearing on decision-making for the Sick Kids?

A I can't recall. I'd just be guessing about-- I totally-- I cannot recall that.

Q Okay. Was there a sense, so far as you recall it, from that meeting, that events or what was known at the Queen Elizabeth Hospital had a bearing on the decision-making for Edinburgh?

A I think it would have been in everybody's mind in the meeting, and I think-- I'd like to think through this sort of situation and think, "Well, what's the worst thing that can go wrong here?", and to me – this is my personal judgment – actually moving into a hospital and then suddenly finding that patients were getting infections that nobody was planning for them to have, that issues were arising that hadn't been fully worked out, and we're having to do remedial work on the hospital with patients in situ causing further risk to patients, you know, I thought, "We just do not want to get into that position."

Q Okay. What you have just said reflects what you say in your statement. So if we could just have that up on screen, it's witness statement bundle volume 1, page 297, paragraph 55, and what you say there is:

> "I think there was particular caution due to the late discovery of this problem. In my experience, when one problem of a major magnitude is discovered at very short notice, very often other problems will emerge. These issues rarely happen in

isolation. The priority considerations were clinical safety for patients, public confidence, staff confidence, and not putting anyone in harm's way. We needed … time to get this right."

Can you just explain why the emergence of one issue made you think that there might well be others?

A Yes, well, I've learnt in working in organisations that sometimes you have a presenting problem and then there are a number of other related issues that subsequently present. So I just had a sense-- My instinct, my judgement, my experience instinctively told me that if something of this magnitude has arisen this late in the process, and knowing that the Board were working incredibly hard to get that hospital ready and it was pretty nip and tuck to get it, my instinct told me there may well be other things that would emerge, and so it proved to be.

Q Okay, so just a precautionary approach, if I can put it that way.

A Well, in my experience, and having been a chief executive of a number of boards and NHS trusts, personally, I lean very heavily on clinical advice, on public health advice, on infection control advice, and would not wish anything to be done under my watch that would put patients into a position where all of those boxes had not been ticked, the risk assessments hadn't been done and we weren't absolutely clear that this was an appropriate environment for patients. Because the consequence of not doing that and something happening to a patient and the loss of staff confidence-- So what we don't want is senior clinical staff saying, you know, "We've got a problem here and I'm not confident to operate on patients in this environment."

And, critically, the public confidence. This is the newest children's hospital in Scotland, brand new, so to open it and find that these sorts of issues were emerging, what we don't want is families coming in thinking, "I'm not sure if my child is going to be safe here." So I think taking a precautionary approach, in my judgment, was the appropriate thing to do.

Q Okay, and you explain in your statement that there was a letter produced to reflect the outcome of that meeting, and that is at bundle 7, volume 1, page 79. Do you recognise the letter?

A I certainly do.

Q Yes. So it is on your headed notepaper as director general and chief executive of NHS Scotland, dated 4 July 2019. It is to Tim Davison at NHS Lothian. So the letter runs in your name, but does it reflect what the Cabinet Secretary wanted to do?

A Completely, and this is issued under her authority, and it reflected the outcome of the meeting that we had in her office that she chaired and listened to the advice of all of her advisers and took the decision that she took.

Q Okay. To what extent was the Cabinet Secretary's decision about how to proceed different from the plans which Mr Davison had outlined the day before?

A Yes, I mean, I heard Mr Davison's evidence, and I hope I'm quoting him correctly, but I think he was really saying that options 3 and 4 were coming together. The written preferred option, to my memory, had moving DCN and ambulatory paediatrics as planned, and I think what the Cabinet Secretary did was to bring what I would describe as a decisive clarity to say, "Actually, we're not going to do that, and we're going to hold everything until we've worked all of these issues through."

So I think Tim and maybe John were describing that the discussions were moving in that direction, and I think what the Cabinet Secretary did was to say, "I've heard all of that. Actually, this is what I think as Cabinet Secretary we're going to do, and we need to do," and, actually, I don't think it was a million miles from what Lothian thought, but it needed that clarity of decision-making, and that's what she brought, I think.

Q Okay. I mean, I think what Mr Davison had said in his email the day before was that the preferred option was for rephasing the timing of the move and that there would be a clinical risk assessment so that the phased moves could be planned. So, essentially, everybody is sort of moving towards the same decision. Is that a fair way of putting it?

A I think so. From the evidence I've heard and what I knew at the time, I think it was moving, and even those four options were constantly being worked. I think the point was that we need to do the work, we need to do the risk assessments, we need to know what the infection control assessments were going to be, and we just needed to do that work and not proceed with the move on the Friday.

Q I think that there may,

among some people, have been a perception that the Cabinet Secretary was essentially stepping in to stop something that was otherwise going to happen, but it sounds from what you are saying that that is not really what was going on.

A I mean, the Cabinet Secretary is elected and she's accountable to Parliament, and there was a lot of work going on in government and in NHS Lothian and between the two, and it was moving. I think everyone was clear that a decision was required, and I think what the Cabinet Secretary did was to say, "I'm going to make that decision," and I think that was an appropriate thing to do.

Q Yes, okay. So, she has effectively placed herself in the main decision-making role about this?

A Yes, as she has a duty to do and is accountable to Parliament for.

Q Yes. In your letter, there are action points about the government wanting assurances about certain things. First of all, that there were no other material deficiencies, and secondly, that there would be no migration of services to the new hospital without clearance that all of the Facilities met the required technical standards. Is it fair to say that she was looking for assurances about things which under the procedures for healthcare projects up to that point would have been left to the health boards?

A I think that is fair. I think up until that point, we would have expected the Health Board to have got all of those assurances in place. So, all the tests done, all of the documents signed, going through the relevant committees and groups so that a decision could be taken to say, "Right, that's all done. We can now start to move patients in here and we can be confident of that." That's what we would normally expect of any board, and I think what the Cabinet Secretary was saying is, "There's still a lot of work to be done here and I want assurance because I'm accountable to Parliament, and I've made this decision that this is a safe environment for patients to move into."

Q Okay, and just to be clear about it, it wouldn't previously have been part of the process for the Scottish Government to obtain assurances about these things?

A No, because we would rely on the boards to do that.

Q If we just return to the letter, we have-- if you just-- the

opening paragraph there, Mr Wright. After the introduction, your letter says, "There are a number of actions that I now require you to undertake," and then there's the list of bullets, and if we could just scroll down through the letter, we have all these action points. Your letter concludes by saying:

> "I require your immediate confirmation and understanding of the terms of this letter and the points raised."

On one level, asking for immediate confirmation and understanding reflects the gravity of the situation, but is it fair to acknowledge that it was Mr Davison who had already raised the issues, and perhaps thereby demonstrated that he had already understood the gravity of the situation?

A Well, I was in no doubt at all that Tim Davison understood the gravity of the situation. What I was asking him for was his confirmation that he understood what was in this letter, and this letter was very carefully constructed. It was planned to be concise, business-like. I sometimes think it's more difficult to write a short letter than it is to write a long letter. So, a number of colleagues within the government were around, "Let's just get this wording as precise and clear and unambiguous as we possibly can, because this is a letter that is going to be examined and scrutinised by many, many people." Now, at that stage, I didn't know there was going to be a public inquiry, but I knew that this would be scrutinised within Parliament and within Lothian Health Board and by elected representatives and others. So we had to get this letter as good as we could get it.

Q Okay. Ms Freeman, in her own witness statement, acknowledges that some might describe her approach to this as "too high-handed." Those are the words that she used. What were your views about that?

A I think Ms Freeman had the benefit of a pretty incisive intellect. She read her stuff and she was able to ask incisive questions and, certainly, working with her around different boards, some boards were really well-prepared and could answer those questions, some boards were less well-prepared. I think when she asked a question that she thought she knew the answer to but the Board itself didn't know the answer to, I think-- you know, people-- She's described that of herself, "I didn't see that at all." What she was looking for was a deep understanding and to be able to

answer these sorts of questions, so I wouldn't characterise it that way.

Q Okay. I mean, one might read the letter and conclude that the government had lost faith in NHS Lothian's ability to make decisions. Is that-- Well, was that the attitude underlying the letter?

A I wouldn't characterise it in that way. I think the view was taken by all of us, and by the Cabinet Secretary, that what we need is a clear decision, clearly articulate that actually we're not going to move forward with this on Friday, and we're going to put in place a range of measures to make sure that remediation has taken place, to make sure that we've got to the bottom of any other issues that might take place. I know we'll come on to the escalation, but that is part of it. That we'd have the Oversight Group that would channel that information and scrutinise that information, and that we'd have externality by HFS and HPS around that table, and that the Cabinet Secretary herself, having made the decision, would then say, "Yeah, that's okay, we can now move to the next stage."

Q Once the decision was taken, what steps, so far as you know, were taken to communicate it to Mr Davison?

A Yes, I heard Mr Davison's evidence and I acknowledge that, and I think if I'd been on the other side of that, I would have hoped to have got a phone call from somebody in government to say, "Look, this is coming in ten minutes and just sort of prepare yourself for it." So, the communication of this decision I think we tried to get-- and I made sure-- tried to make sure that we got the letter out before the press release went out, so that it would go straight to his inbox and the intention was that he would see it. But I do accept the point from his perspective, had I been in that position, I would have appreciated somebody picking up the phone and saying, "This is about to happen." As did John Connaghan, the night before, have a conversation with him about the communication plan. I take his point.

Q Are you able to offer any explanations to why that was not done?

A Yes, I think two things. I think one would be my own personal caution about communicating ministerial decisions until they're actually done. Secondly, and I don't think this is a-- You know, we were all running around in government doing a lot of things to manage all of this, but

in retrospect would I have done that? Yes, I would.

Q Yes, so just to be clear, when decisions of that magnitude are being taken which affect a health board, better to make sure personal contact has been achieved----

A Absolutely.

Q -- with the chief executive before any public announcement.

A I accept that.

Q My Lord, I note the time, it may be a convenient moment for the mid-morning break.

THE CHAIR: Yes. Mr Wright, as I said at the beginning of the morning, we usually take a coffee break about this time. I see it now is twenty-five to twelve. If we could be back for about roughly ten to. Thank you.

THE WITNESS: Okay, thank you.

(Short break)

THE CHAIR: Mr McClelland.

MR MCCLELLAND: Thank you, my Lord. Mr Wright, you will recall just before we broke for coffee that we were looking at your letter of 4 July 2019. We can perhaps see how the Cabinet Secretary's own thinking was evolving by looking at a briefing note that she prepared for the First Minister on 5 July, so the following day, and that is at bundle 13, volume 3, p.1144.

THE CHAIR: Thank you.

MR MCCLELLAND: Can you see the----

A No, I can't.

Q You do not have it on your screen? I do not have it on my screen either. I wonder if----

THE CHAIR: I will have it in my bundle somewhere, if this is the most convenient copy.

MR MCCLELLAND: Thank you, my Lord. Does your Lordship have access to a copy, or----

THE CHAIR: Well, I can go back to it.

MR MCCLELLAND: Yes, okay.

A I've got my copy here, your Lordship----

THE CHAIR: All right. Okay.

A -- and I'm happy to use that if that would----

Q Thank you. Thank you.

MR MCCLELLAND: This is a briefing note that you refer to in your----

A Got it.

Q Good.

THE CHAIR: Thank you.

MR MCCLELLAND: Perfect, thanks very much.

THE CHAIR: Thanks, Tim.

MR MCCLELLAND: Well, with

the benefit of that timely technological intervention I think we all now have access to the document. So, what we see on screen, Mr Wright, is a briefing note which the Cabinet Secretary prepared for the First Minister, and it is one that you refer to in your witness statement.

A Yes.

Q I am not going to read through the whole thing, but just picking up under the section "Background," and the second bullet point, what she says is:

> "I have also asked that we undertake an external series of checks, led by Health Facilities Scotland and Health Protection Scotland, to ensure that all the relevant technical specifications and standards applicable to the new Edinburgh Children's Hospital are being followed and implemented."

Then if we read forward to page 1146 under the heading of, "Update on the work required," she says:

> "My officials received a proposal from NSS which is being reviewed by officials. There is an initial estimate that a comprehensive review of the new site could take as long as four months to complete. Malcolm Wright has spoken to the chief executive of NSS on Friday afternoon with a view to setting a speedier time frame. If this involves additional resources we will ensure that this is made available."

So, is this the review which had been mentioned in your letter, essentially looking beyond the issue of the critical care ventilation to the other systems in the hospital?

A Yes, and that's the government asking National Services Scotland and HPS and HFS to get the capacity in order to do that review that would really look at the safety of the whole hospital and give the Cabinet Secretary that assurance.

Q And we perhaps get an indication from that briefing note that this is going to be a fairly significant programme of work?

A Yes.

Q Then if we go forward to page 1147 there is a heading, "Role of HFS in all future builds for NHS Facilities," and the Cabinet Secretary says there:

> "My officials have today received a proposal from NSS which is currently being reviewed. There will be resource/capacity implications to consider for this

and the other Sick Kids' reviews, given existing commitments to QEUH review, etc."

So that is a reference there to the role of HFS in future builds, and can you just explain to us what the thinking was at that time? So this is back at 5 July.

A Yes, and I think this indicates that, at a very early stage, we were thinking along the lines of what has become NHS Assure, and that when we-- when you were asking me questions earlier about the relationship between government and boards and I was making the point of externality, this is the genesis of that idea, that as projects progressed from stage to stage, there would be an external expert view that could go in and challenge the Board and look at the document-- the documentation and speak to people and be assured that this was okay to proceed to the next stage.

Q Yes. So, a recognition – even just two or three days after the issue emerging at the Edinburgh hospital – that there was a need or a case for more assurance being given to of the government about healthcare projects and their compliance.

A Yes, and it was one of the early conversations the Cabinet Secretary and I had, and you'll see from my evidence that when it came to light, that was one of the first questions I asked about the involvement of HRS and HPS.

Q Okay, and then if we could move back, please, to page 1146. Again, under the heading of, "Update on the work required," the second bullet reads in part:

"The revised migration plan needs to be reviewed by HFS/HPS to ensure it can be actioned safely."

And then the third bullet:

"However, there is probably a good clinical case to prioritise migration of the Department of Clinical Neurosciences (DCN) in advance of other services. Delay to the migration of DCN services is not felt to be risk free; the fabric of the unit is poor and there have been increased pseudomonas infections; angiography equipment is aged too. The reduced occupancy associated with transfer of DCN would have allowed remedial work in the ITU normally used by DCN where a recent pseudomonas HAI was diagnosed, but this can no longer take place."

So, what was your understanding of the perhaps different considerations that applied to the DCN relative to the RHCYP?

A There was a stronger case-- a stronger case to move DCN as quickly as we possibly could, and I think other witnesses have described but I understood it at the time, the infection control challenges that were in existence at DCN and the mitigations they'd had to put in place in terms of reduced levels of service, closing areas off. I think Alex McMahon described the incident management team that he was chairing. So there was a lot of work had gone on to mitigate the risk, but it was not risk free, and the sooner we could get DCN in the better.

Q Okay, and is it fair to acknowledge that Tim Davison at NHS Lothian had himself recognised that and that there were perhaps different considerations for the migration of that part?

A I would say unequivocally, yes.

Q Now, we talked earlier this morning and you have covered in your statement the escalation framework and the escalation of NHS Lothian first of all to Level 3, and then secondly to Level 4, and I think we have probably already covered the generalities of that, except perhaps to ask this, is the escalation framework a system which works well, in your view, for the purposes that it has?

A Do you mean in general terms or in this specific case?

Q In general terms, but if there are particular points arising in this case, then please do let us know.

A Yes, I do, in that it was overseen by the Health and Social Care Management Board. There was multi-professional input into it. We tried to keep boards as low down the list as we could, and it was a trigger to put in resource, be it people or money, into boards to help them at that position. I think in this particular case it worked well, and I understand the comments made about, "This feels punitive." When you're on a board it can feel that way, but I think if you read the paper that went to the Management Board about this particular escalation and the letter that I sent to the Health Board following it, I think it is clear that this escalation is in relation to what has happened with this project.

I use the word "cumulative impact," I think, in my letter, and that is because something of this magnitude going wrong in one of our major

boards that has already got performance challenges is going to take away a lot of senior management and governance time and attention, so we need to put in support on both levels. We need to support the ongoing improvement of performance, and I think it's fair to say that the Board were improving in a number of areas. There were areas such as mental health that have come on to the radar as particular problems.

So it had put support into the Board and John Connaghan took the lead role in that, and I believe there's a letter in the pack that identifies half a million of funding that went in on the back of that, and then on the project itself it enabled the establishment of the Oversight Board and, as I say, putting in the chief medical officer, the chief nursing officer, Christine McLaughlin. So, actually, a number of the senior directors in Scottish Government, one way or another, were deployed to help Lothian to get this project through and to keep the performance to the public continuing to improve.

Q Okay, and we discussed this morning that decisions on the escalation framework are discussed by the Health and Social Care Management Board, and I think I am right in saying it is ultimately a decision for the director general?

A Yes.

Q And you mention in your statement that in relation to this particular-- or these particular escalations, that you consulted the Cabinet Secretary about it. Can you just explain what those consultations were about, and is consultation with the Cabinet Secretary about these sorts of decisions a normal part of the process?

A Well, the decision is for the director general to make, and for the director general to make in the role of accountable officer, and that's what I did. The Cabinet Secretary and I would have regular conversations about a whole range of things. So I would tell her what I had in mind, she would be relaying to me concerns that-- any concerns that she had, but the decision was mine.

Q Yes. Okay. Sorry, I am not sure if you answered this question, is it a normal part of the escalation decision-making process to discuss it with the Cabinet Secretary or was that something that was particularly done because this was a challenging project?

A No, I wouldn't-- I didn't adopt anything other than my normal

practice. This particular paper I think was drafted by John Connaghan and two of his senior advisors. He brought it to the Management Board, we had a full discussion about it and, you know, there was a clear decision made that we need to support the Board with its performance and we need to set up the Oversight Board, but, of course, I would be having constant conversations with the Cabinet Secretary on a whole range of issues and we regularly talked about the performance challenges of different boards around the country.

Q Thank you.

A But, you know, if the question is, is this my decision, yes, it is.

Q Yes. If we just look briefly at bundle 7, volume 1, at page 339, this is your letter of 12 July 2019----

A Yes.

Q --- to Tim Davison at NHS Lothian, essentially communicating to him the decision to escalate that health board to Level 3.

A Yes.

Q And I think if you just take a moment to look at that letter, do we see, I think this is what you said a moment ago, that the RHCYP issues were simply an additional element on a list of challenges faced by the Health Board, and is it correct to view it as the issue which perhaps tipped the question into escalation?

A Yes, it was recognising that an issue of this magnitude would occupy a huge amount of senior management and governance time and effort, and Lothian was already making progress on some of the issues. There were new issues arising, and the really important thing was that we continued to improve delivery of services to the public of Lothian while we also sorted out this problem. This, therefore, needed additional heft, if you like, to the Board to help this to happen. So the two were connected and they were always connected in my mind.

Q Okay, and in terms of the concrete form that the support took, you have referred to the formation of the Oversight Board, and we will have a look at that in just a moment, but did you also say that there was additional money made available to NHS Lothian?

A Yes, I think there's a letter in the pack that was written by either myself or John Connaghan, going through the different areas of performance and the conversations that had been had with the Board, and

at the end of that letter there's an amount of resource that is going into the Board to support the continued improvement of performance.

Q Yes, I think if we go to bundle 7, volume 3, at page 27. Sorry, page 27. I think this may be the letter that you are referring to.

A Yes.

Q So this is-- it is actually from John Connaghan----

A Yes.

Q -- and it is to Tim Davison, 13 August 2019.

A Yes.

Q Okay, so that was the letter that you were referring to. Thank you.

A And I think on the second page there is another financial figure. Or even the third page, at the end of it anyway. Yes.

Q Yes, that is right. So, thank you very much, Mr Wright. So paragraph 8, support package, it says:

> "In paragraph 8 of your letter you have set out the main elements of the support package that you require. We are content to provide some financial support in relation to the senior programme/director/management resource that you require in relation to recovery, mental health and support for waiting times improvement. To this extent we will make available £500k [and so on]."

So that was the figure that you referred to. Thank you. If we could then, please, go to bundle 13, volume 3, page 1149. These are the terms of reference for the Oversight Board, and the role and function of the Oversight Board is something that has been covered with other witnesses, but if we could just go for the time being, please, to page 1152. We can see there the list of members----

A Yes.

Q -- of the Oversight Board, and also the list of those to attend the Board to provide it with advice and assurance.

A Yes.

Q And if we just look down the list, we have got the chief finance officer, chief medical officer, chief nursing officer, all from the Scottish Government, some senior officials from NHS Lothian, Mr Reekie from the Scottish Futures Trust----

A Yes.

Q -- the chief executive of NHS NSS, and various other people. So, I think, no question about it, there

is some senior firepower being allocated to this.

A Yes, indeed, and I think the attendance or the membership of the staff side, so the trade unions there I think were really important as well, but you're right, this was serious heft going into the Health Board to work with them to work through these issues.

Q And can you just explain the thinking behind putting together a team of such senior officials?

A Because this was such a pivotal project for the National Health Service in Scotland, and it was so important that we got this building finished and opened and safe and patients being treated, it was so important that we got patients out of DCN and the existing Royal Hospital for Sick Children. It was one of our major projects and it needed that amount of support to get it through.

Q Okay, and we referred a moment ago to the commissioning of the additional work from NHS NSS, and there was also work done with KPMG----

A Yes.

Q -- in relation to the governance aspects of the project, and you explain in your statement that this led to the further escalation of NHS Lothian to Level 4 of the escalation framework. Again, could you just outline your understanding of the reasons why that was done?

A Yes. The difference with the second escalation was that the second escalation was for the project and not for the Board, and the publication of the first of the two NSS reports demonstrated that, actually, there was a number of other very significant issues in terms of the major recommendations that that had shown us. I think as Professor McQueen said to the Inquiry, there was a lot more work in that than had been anticipated, and actually to get this project really through and over the line, it gave us the opportunity to appoint Mary Morgan reporting into government. I think Mary brought huge skill and expertise and knowledge and, I think, widely won the confidence of the people that she was working with and helped us to get this project to what I think she described as one of the very safest hospitals that we've got anywhere.

Q Yes. So, if we just sort of boil it down, the escalation to Level 4 was in relation to the project and, in short, intended to provide NHS Lothian with the additional management support or resource in order to deliver

the work identified in the NSS report.

A Yes.

Q Yes. Now, the escalations in the support framework come, essentially, at the end of the project. If one looks at the project to build the RHCYP and DCN as a whole, there are two escalations right at the end to complete the project, if I can put it that way. One understands the reasons for those decisions being taken at the time they were taken, but is it possible to take the view that the government support came too late, that, actually, in delivering a complex acute hospital, the Health Board would have benefited from additional support at an earlier stage?

A Well, it depends what level of support. I mean, the Board was already getting performance support through John Connaghan and his work, so I think the letter that he sent also demonstrates just how much support they'd already had. So, we were dealing with the Board equitably, in the way that we deal with all other boards in terms of their general performance. I think in terms of lessons learned, it seems to me that the size and complexity of this project and the government's arrangements that were put in place, which the KPMG report says they did what they were meant to do. But looking back on it, I think it would have benefited from externality and challenge at different stages from an external source. So I wouldn't in any way wish to take away from the Board its set of responsibilities, and I think if the Board needed more help with the running of the project, that was something that could have been raised. I don't know if it was raised. I'm not aware of it being raised.

Q Okay.

A And I think I'd also point out that the Cabinet Secretary, I think, had an annual review with Lothian just before all of this came to light, and it's certainly not within the letter that came out, and I'm not sure if it was raised with the Cabinet Secretary. So we need to be asked, I think, for project support. We might not be able to do it, but we would have the discussion with the Board.

Q Okay. Part of your answer there, you used the term "externalities". Is that a reference back-- I think it was a term you used earlier on, and is that something that you would see now being provided by the service of NHS Assure?

A I think it's very much a work in progress, but I've listened carefully to a lot of the evidence

sessions, and I must say I am heartened by what I see. I think the key stage reviews are hugely important, and that's the kind of discussion the Cabinet Secretary and I were having and is reflected in that note to the First Minister two days after the thing had happened. So, I think for a good system of governance to work, it needs expert people in the right place, giving challenge into the system to make sure that things are spotted and things are sorted out before they need to, so I think what I see in NHS Assure is very much on the right track. I commend what I've heard that they're doing around developing the workforce, so the building and engineering staff in the NHS in Scotland, the people who are leading the projects; and my old organisation, NHS Education for Scotland, I believe has got a role in supporting and developing that workforce. I think that's all to the good.

Q Yes. Okay. I think, put this part of your evidence into context, it is fair to acknowledge that you retired before NHS Assure was set up, and indeed before the migration of the services to the new hospital took place. So the baton in some senses had been passed on to other people. One thing that you rule out in your statement is the idea of the Scottish Government having its own centralised capital planning function for healthcare buildings. Can you just expand on your reasons for that?

A Yes. I mean, others may disagree, but I think the role of government is very much about policy, about ministerial direction and making sure that health and social care services deliver, and holding the system to account. I think having a local statutory body, a health board that's set up in primary legislation, that's got all of the stakeholders around the board table – it's got the staff side involved; it's got the trade unions involved; it's got infection prevention and control; it's got the building people involved – and it's close to the patient interface and it can have close discussions with the clinicians about what is actually needed out of this facility, I think that is a much better place to have those projects run from, rather than in government.

But I do think that health boards need external support to help cross-check that everything is okay. Not just to cross-check, but if capacity is needed – and I think this was described in some of the sessions yesterday – then that capacity can be

provided centrally and can be moved around the NHS in Scotland. It always seemed to me that one of the great strengths of the NHS in Scotland is if we have a problem over there, we can identify an expert over there and say, "Look, will you go and help that board out, please?" So I think the Board is the place, as the accountable body, where this should rest.

Q Okay.

A Personal opinion.

Q I mean, that question was concerned specifically about the Scottish Government having the capital planning function, but can I take it from your answer that you would apply the same reasoning to any notion of there being a centralised body within the NHS itself to be the construction delivery arm for the NHS?

A Yes, I would think that because I think boards are best placed in their local communities with their local clinicians, and actually what we need to be doing is supporting the boards, and, actually, having some of these projects run at a great distance from the Board I think is inviting trouble. So I think the boards are best placed and are statutorily set up to do this work. That's a personal opinion.

Q Okay, and we have already touched upon NHS Scotland Assure, and of course it was set up after you had left office, but what you say in your statement-- and this is paragraph 107 of your statement, which is-- I'm afraid I don't have a page number, but perhaps if we were able to scroll through Mr Wright's statement to page 107, please.

THE CHAIR: Might be 311.

MR MCCLELLAND: It appears to be, my Lord. Thank you. In fact, if you could just go over the page, please. Yes, and what you say there is:

> "As an accountable officer within the Scottish Government, I would want external validation to give me assurance that all is satisfactory … NHS Scotland Assure … will now look at these projects and at every stage of the project there will be an external sign-off to say that they are satisfactory and that the relevant standards are met."

So, just to expand on those points, what was it that you thought, from the perspective of the director general in the government, was needed?

A I think it's what I've already tried to describe, in that I always found it helpful as a board chief executive-- it didn't always feel helpful,

but I always found it helpful to have external folks coming in and scrutinising what we were doing, because that way we got to find out things that we weren't finding out through our own management and governance channels. So having a major project that is highly technical, highly complex-- and this project in particular, with all of the contractual issues that were going on and all of the clinical concerns and the infection prevention and control concerns, I think it would be enormously helpful to a board to have somebody like the centre for excellence coming in and saying, "That's good, that's good. I think you've missed that." Or what would be more helpful would be if you made sure that your infection prevention and control lead staff were involved in this forum and that forum – you're wasting your time or wasting their time having them in that forum – and I was struck by the evidence from IPC colleagues about their expertise and using them effectively, and I think, you know, a centre of excellence could really advise on the governance structure within a board to deliver the outcome of the project.

Q Okay. I mean, the Inquiry has heard evidence from the people at Assure and they have described the way that the system actually works, and they do have an element of that sort of challenge function that you are describing, but what they do not do is sign off and confirm that the hospital, in all respects, complies with the guidance. Do you think that is a shortcoming in the system, or do you think that that is an appropriate place to stop short of?

A I'm not there at the moment, so I don't know, and it may well be a step on a journey, but if I was an accountable officer on a board, I would want an assurance that the new centre for excellence were okay with what we had, and people had been through the paperwork and had spoken to the people and this had been externally assessed, but this may be a step in a journey.

Q Yes. Okay, and a final point about Assure. We've been clear that the responsibility for the construction projects lies with the health boards, firmly in their camp, and what NHS Assure does to some extent is build up a pool of expertise and resource, but it is in another place. So we have responsibility in one part of the NHS and the resources and expertise being built up in another. Do you have any views about whether that is the best way to proceed or should

the resourcing go to the same place that the responsibility rests?

A If I was there now, and I'm not, I think I would want to be very careful that if we're building it up in one place, it's not getting drawn away from somewhere else. So I think the work I see being commissioned, looking at workforce development, so that the boards have got their workforce in place, and there are huge challenges with that, and we're not pulling away some of the very best people from the boards into the new centre. So there's a balance to be struck there and I think it needs to end up as more than the sum of the parts, as it were. We need real-- I'm going to use the word additionality. This needs to be something that is helping and not taking away capacity from the boards.

Q And given your career experience, would you see this as something that there should be ongoing monitoring of to make sure that the systems being put in place are actually achieving the objective that they have set out to achieve?

A Yes, and looking at my time in government and my time as a board chief executive, I would be very confident that those conversations would be going on. I'd be very confident that medical directors, IPC lead doctors will be having conversations with the chief medical officer. The chief nursing officer will be all over the new head of NHS Assure. I'd be absolutely sure that those conversations were taking place.

Q Okay. You have provided us with some interesting and very helpful ideas about how things might be done better or well. Are there any ideas that you have, prompted by the subject matter of this Inquiry, which you have not had an opportunity to explain to us this morning?

A No, I think I've had an opportunity to give whatever evidence I can offer.

Q Okay. Well, thank you very much, Mr Wright. You have answered all of my questions. It is possible that others will have some questions for you, so please stay there for the moment.

A I will.

Questioned by the Chair

Q Mr Wright, I wonder if you could help me with two matters of detail, the second of which is of extreme detail. The first of these is, I think I have understood from your evidence that, I think, as you put it, the genesis of what has become NHS

Scotland Assure was the experience of the Edinburgh hospital, and that genesis had emerged as early as perhaps 5 July. The reason I ask that was in looking at some of the written material, I was not sure if this was an idea that had been around before, but sort of got focus from Edinburgh, but it goes the distance of saying that had it not been for the Edinburgh experience, NHS Assure certainly would not have come into existence as early as 2021.

A That is my opinion, and the conversations that were going on days after this came to light were about, well, how could this have happened? What are the external checks and balances? And then that grew into Assure. Now, that took a bit of a while to work its way through, given that we were dealing with a crisis situation, but my view is that that was the germ of it there.

Q Right. Now, the other matter of fine detail – I am almost embarrassed to ask the question – arises from, I think, paragraph 23 of your statement, and you made some reference in your evidence. It is really the Common Services Agency. Now, in the course of this Inquiry, one of the challenges for me has been to follow the various "bodies," and I use the expression deliberately vaguely, that contribute to the NHS in Scotland. Now, I think I had got it into my head that the Common Services Agency, as a statutory body, continues to exist.

A Yes.

Q However, it now describes itself as NSS. Have I got that right, or have I got it wrong?

A I think you have it absolutely so. I think the statutory name of what is now known as NSS is still the Common Services Agency, but you will have it more right than I do.

Q The final matter is maybe a rather broader question. Mr McClelland has been asking you questions about where responsibility for capital projects and the immediate supervision of construction projects, which are an example of a capital project, should be, as between Scottish Government and Scottish-- and the regional health boards. As I have noted you-- and this was earlier in your evidence, I have noted a phrase you used, "The Health Board delivering to a local population." Do you have any observations about, in very broad terms, what is, in your view, an effective structure for the delivery of health services?

As I think you identified, if we look at the National Health Service Act of 1978, we see there is, as you said,

specific provision for health boards and functions that they have. It might be said that the evidence of Ms Freeman indicated a tendency towards preference for a central responsibility, as opposed to a local responsibility. Now, what I picked up from your evidence was a preference for a local-focused responsibility, so I will just invite you maybe to tease out your thinking on that.

A Okay. I think what I heard Ms Freeman say was her view that health boards are the delivery arms of the National Health Service in Scotland and given ministerial-- given the powers given to ministers under parliamentary acts, ministers have got very considerable powers. I think I would add to that in that having health boards as statutory bodies, and there's always a debate about how many and what configuration, but what I've learned in my time is that having health boards working with local authorities, and fire and police, and working in local communities, that health services and health improvement are things that need to be delivered locally in a way that meets the needs of local populations.

So, I remember when Ms Freeman and I visited Skye and saw the configuration of services in that place, and how the board were working with local communities and with voluntary organisations to bring real resilience to services there; not just hospitals but primary care, the lifeboat service, for example, the helicopters and how do you get patients off the island in an emergency. So, healthcare has to be delivered locally. It has to be arm in arm with local authorities, in my view. There are distinct functions there and it has to be done on the basis of local partnership.

So, I don't think it's an either/or. I think government has a clear responsibility to set the policy, and that's what elected ministers do, to allocate the budget, to set the outcomes that they want to see delivered and hold the system to account so that those resources are actually delivering the outcomes that policy has decided. That all needs to be done in the context of local communities. Given that government policy affects local authorities and housing and social services, that all needs to come together in some sort of a local manifestation. Certainly, my experience of working in Grampian, and in Tayside, and up in the Western Isles, you really are working hand in glove with your local authority

colleagues, and the local police and the fire services and the voluntary organisations. So, it's not an either/or, I think it's a both/and.

Q Thank you, Mr Wright. Now, as Mr McClelland signalled, I would like to check with the room whether there's any other questions that might be asked. So if I could ask you to go back to the witness room for maybe ten minutes, something of that order, and then give you an indication of whether there are further questions or no further questions.

THE WITNESS: Okay. Thank you, My Lord.

(Short break)

THE CHAIR: Mr McClelland.

MR MCCLELLAND: Thank you, my Lord. Following discussions with core participants, there are two questions which have been identified for Mr Wright, which I am happy to raise with him.

THE CHAIR: All right. Mr Wright, there is perhaps two questions which Mr McClelland will pursue with you. Mr McClelland.

MR MCCLELLAND: Thank you, my Lord. First of all, Mr Wright, you may recall that, in the course of your evidence, one of the things you said was that NHS Lothian had specified 10 air changes per hour for the critical care rooms. At least that is what I understood you to say. Do you recognise that the interpretation of the contract and what exactly was specified in it is a matter which the parties to that contract would regard as a contentious one?

A Yes, I do.

Q And can we take it that you are not purporting to offer a definitive view on what that contract means?

A Correct.

Q Secondly, you covered in your evidence what was done within the government in July 2019 once the issue with the critical care ventilation emerged. At that time, was the focus within the government simply on dealing with the emergency response to that issue, or was there any investigation done into how that issue had come about?

A I think it was a bit of both. I think the primary focus was to understand what the issue was and to get briefing to the Cabinet Secretary. I think Alan Morrison's initial note to the Cabinet Secretary postulates some reasons why the matter may have arisen, but there was nowhere near enough time to come to a full

understanding as to why the matter had risen. So a lot of the attention was focused on, well, what we're going to do.

Q One of the emails from-- either an email or a note from Tim Davison around that time says that one of the things NHS Lothian were doing were looking into how the issue had come about.

A Yes.

Q Was that the source of information coming into government about the source of the problem, or was the government able to carry out any investigations of its own into that?

A No. My understanding was that the government were drawing advice from NHS Lothian in the very early stages of that. I think, from my reading of the evidence, is that by the time the following day, and the two meetings that took place the following day, HFS and HPS were involved in that, but, no, the primary source of information coming through was from Lothian Health Board.

Q Okay, and so far as you were aware, and insofar as investigations were done at the time into how the issue had arisen, did that detect any red flags or warning indicators had been revealed at earlier stages that there might be a problem with the ventilation in critical care?

A No. I mean, my initial assessment of it was based on what the chief executive told me, in that the issue had come to light to Lothian at the end of the previous week. It had been escalated through. The medical director had been told about it. Tim called a meeting, I think, on the Tuesday morning, put in a call to my office, and immediately escalated it to me.

Q Okay, and in all of those discussions that you had at the time, was there ever any indication to you that this was an issue which might have been detected at the tender stage of the contract?

A No. There was no ability at that stage with the speed of what was going on to come to any sort of view within government as to why that might have happened. I think some of those issues came out later with the KPMG report and the Grant Thornton report, but there was no way that the government could take a view on that at that early stage in the proceedings.

Q Thank you, Mr Wright. That answers the additional questions.

A Okay, thank you.

THE CHAIR: Thank you, Mr McClelland. Mr Wright, that is all the questions that we have for you and

you are therefore free to go, but before you do go, can I express my thanks for your attendance, but also for the preparation of your statement which I appreciate will have involved significant work, and so can I repeat my thanks, but you are now free to go. Thank you very much.

THE WITNESS: Thank you.

THE CHAIR: Now, Mr. MacGregor.

MR MACGREGOR: Thank you, Lord Brodie. Just to confirm that that concludes all the witnesses to be led at this set of hearings. There is obviously no intention then to sit in the fourth week that had been reserved. The only final housekeeping matter would just be to remind core participants of the guidance that has been issued in relation to closing submissions, and to confirm once again that the timetabling proposed for closing submissions, which would be counsel to the Inquiry to lodge submissions by 6 May, core participants to lodge any submissions by the 27 May with oral submissions taking place on 17 June and subsequent days with further guidance on timetabling and timings to be provided in due course.

THE CHAIR: Thank you, Mr MacGregor. Well, legal representatives will be aware, I hope, of the terms of direction 6. Mr MacGregor has reminded us of the timescale within which I would invite closing statements from core participants in response to counsel to the Inquiry's closing statement. Can I just repeat and emphasize that I look forward to your assistance in fulfilling the terms of reference of the Inquiry insofar as they relate at this stage, insofar as they relate to the Edinburgh Hospital.

I anticipate that core participants would wish to do this, and certainly I will welcome all assistance that you have to offer. Until perhaps the date for oral submissions, I should say a goodbye and hope to see you again, but before you go, can I thank you for your attendance and the contribution you have made thus far. But I think we should congratulate Mr McClelland on his timing, bringing us to a conclusion just before one o'clock. I think that is the end of proceedings for the moment, so thank you Mr McClelland, thank you Mr MacGregor and thank you to everyone in the room.

(Session ends)

13:01