Scottish Hospitals Inquiry

Witness Statement of

Malcolm Robert Wright OBE

Dated 18 December 2023

Introduction

1. I am Malcolm Robert Wright OBE. I am retired, having worked within the National Health Service (NHS) and Scottish Government until July 2020. The last role that I held before retiring was Director General (DG) of Health and Social Care within the Scottish Government and Chief Executive NHS Scotland.

2. In this statement I address the following:

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2.14. Escalation to Level 4

2.15. Phased Migration

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Professional Background and Qualifications

3. My Curriculum Vitae (CV) is produced within **(A46527591 CV of Malcolm Wright – December 2023 - Bundle 13, Volume 3, Page 942).** I was made a Companion of the UK Institute of Healthcare Management, the NHS UK-wide management body, in November 2006 and served as Vice Chair (2008 to 2010) and then Chair (2010 to 2012) of that body. I was appointed as a Fellow by the Churchill Fellowship in 2017; I hold an Honorary Fellowship of the Royal College of General Practitioners, having been appointed in November 2007; and am also an Honorary Fellow of the Royal College of Physicians of Edinburgh. I was awarded an honorary doctorate from the then University of Paisley in November 2007 and was awarded an OBE in January 2008.

4. I held a range of roles within the then Lothian Health Board, now referred to as NHS Lothian (NHSL), between 1975 and 1989, ultimately holding the post of Operational Services Manager at the Royal Hospital for Sick Children in Edinburgh. I held the role of Hospital Manager at Great Ormond Street in London from 1989 to 1992. My time within these roles provided me with a good grounding in paediatrics and child health care as well as experience of working at a major London teaching hospital.

5. In 1992 I was appointed as Unit General Manager for NHSL based at the Royal Hospital for Sick Children (RHSC) at Sciennes, Edinburgh. In this role, I had responsibility for hospital services and paediatric services. I was also responsible for establishing the RHSC as an NHS Trust, The Edinburgh Sick Children's Trust (ESCT), in 1994. I was Chief Executive at the ESCT from 1994 to 1999. I then became the Chief Executive of the Dumfries & Galloway Acute National Health Service Trust and held this role from 1999 to 2001. I became Chief Executive of the Dumfries & Galloway Health Board in 2001 and held this role until 2004.

6. In 2004 I was appointed as Chief Executive of NHS Education for Scotland (NES). NES is the national body responsible for the postgraduate medical, dental and other education for the whole of the NHS in Scotland. I held that position from 2004 to 2014.

7. Throughout my time as Chief Executive of NES, I received requests from the Scottish Government to carry out roles in different parts of Scotland. This resulted in me leading a Ministerial support team at NHS in the Western Isles in 2006. I was then asked to go to NHS Grampian, where I led a team of clinicians and managers in resolving challenges with relationships and service delivery there. I became interim Chief Executive of NHS Grampian in December 2014; and was appointed Chief Executive for NHS Grampian in July 2015, holding that position until September 2018. Following a request from the Scottish Government, I led a team in NHS Tayside to support system recovery and was subsequently appointed as Chief Executive of NHS Tayside, holding that post from April 2018 concurrently with my role as Chief Executive of NHS Grampian until December 2018, when I intended to retire.

8. I chaired the Ministerial Review of Specialist Services for Children from 2006 to 2009; and chaired the Scottish Government Ministerial Children and Young Peoples Support Group from 2000 to 2018.

9. I then was approached by Leslie Evans, then Permanent Secretary to the Scottish Government, who asked if I would help on a temporary basis when my predecessor, Paul Gray, resigned his post.

Role as Director General for Health and Social Care / Chief Executive for NHS Scotland

10. On 11 February 2019, I was appointed as interim Director General (DG) of Health and Social Care within the Scottish Government and Chief Executive NHS Scotland. I was then appointed to these roles on a permanent basis on 17 June 2019 following a full external civil service recruitment process. The role of Chief Executive of NHS Scotland is not a statutory position but flows from being the DG. The role of DG is a unique role that combines the strategic policy and whole-government approach with the operational responsibility for the NHS. There is no other DG within the Scottish Government that has that level of responsibility. I was the accountable officer for the Health and Social Care portfolio budget, which was roughly £14 billion at that time.

11. The role is multifaceted and requires an in-depth understanding of how the NHS works. The Permanent Secretary, with whom I met regularly, looked for the DG to be part of her corporate team, with responsibilities across government, a strong emphasis on working collaboratively and undertaking a number of cross-portfolio activities (for example I co-chaired the Health and Justice Collaborative Improvement Board (HJCIB), which was set up to draw on senior leadership across health and justice to look at how the NHS, Police and social justice colleagues could work together to get better outcomes for people in communities).

12. A critical aspect of the role was supporting the Cabinet Secretary for Health and Sport. As a principal policy advisor to the Cabinet Secretary, my role was to work closely with her, understand her ambitions for the health service, provide advice and make sure that the civil service and the NHS were delivering against the Scottish Government's policies for the people of Scotland.

13. The Scottish Government operates a director-led model, with Directors having direct access to Ministers. Directors have their areas of work and will put briefings and submissions to Ministers on an ongoing basis. I oversaw the Directors and I reported directly to the Cabinet Secretary. The team worked cohesively with other parts of government and linked with the NHS to ensure that the Cabinet Secretary was getting the best-rounded advice possible.

14. The other part of the role is acting as Chief Executive of NHS Scotland and accountable officer for the whole of NHS Scotland. As part of this role, I would meet all of the NHS Health Board Chief Executives regularly, both formally and informally. They were accountable officers within their statutory organisations. I also worked alongside the Cabinet Secretary with the Health Board chairs, who are appointed by the Scottish Ministers.

15. Within the Scottish Government Health and Social Care Directorate, which I led, I worked alongside John Connaghan (Director of Performance and Delivery); Catherine Calderwood, and latterly Gregor Smith (Chief Medical Officer)(CNO); Fiona McQueen (Chief Nursing Officer)(CNO); Shirley Rogers (Director of Health Workforce); Christine McLaughlin (Director of Finance and Infrastructure); Eleanor Mitchell (Director of Health and Social Care Integration); Donna Bell (Director of Mental Health); and Richard Foggo (Director of Population Health), who was responsible for public health, health improvement, primary care, and setting up of Public Health Scotland, which was a major development at the time. The Cabinet Secretary met with the whole senior Health and Social Care Directorate team on a weekly basis, immediately following the Cabinet meeting.

The Cabinet Secretary would debrief us on the Cabinet meeting, we would have a collaborative discussion of the live issues being handled by the team. All of these Directors would directly interface with the Cabinet Secretary, providing her with 'real-time' information. I was copied into submissions to the Cabinet Secretary, and I sought to ensure that submissions were cross-checked with other colleagues on the Health and Social Care Management Board (HSCMB) to encourage collaborative working.

16. I chaired the HSCMB, and the Cabinet Secretary regularly attended to discuss her expectations and what she wanted to achieve and listen to the advice of her Directors. The HSCMB terms of reference provide that it is*:*

> "an opportunity for Directors and other key participants to formally meet to discuss strategic, tactical and operational activities which contribute to the delivery of health and care services across Scotland. It provides a platform for the Director General/Chief Executive of NHS Scotland to:
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> - seek assurance on the progress of areas of work;
> - seek assurance that mitigations are in place for identified risks; and
> - to seek advice from her team to enable her to carry out her functions as accountable officer.
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> A number of sub-groups report into HSCMB on various workstreams at regular intervals, providing assurance around delivery and risks, delivering on work commissioned to them by HSCMB, but also highlighting areas for further improvement to HSCMB members."

17. In relation to the Royal Hospital for Children and Young People/ Department of Clinical Neurosciences (RHCYP/DCN) project, the Scottish Government had to sign off various capital projects through its Capital Investment Group (CIG) at different stages. The Director of Health Finance and Infrastructure, Christine McLaughlin, had a key role, supported by Alan Morrison, Deputy Director.

I was not in post when the Settlement Agreement (SA1) (**A32469163 Settlement Agreement and Supplemental Agreement relating to the Project Agreement for the provision of RHSC and DCN between Lothian LB and IHS Lothian Ltd - 22 February 2019, Bundle 4, Page 11**) relating to the RHCYP/DCN was signed off and cannot comment upon it. I expect it would have been reported to and signed off by the Cabinet Secretary due to the level of public funds being committed to SA1. During my time of working with the Cabinet Secretary, she read her briefs closely and regularly asked incisive questions when submissions came forward.

18. I sought to read everything that crossed my desk during my time in post; and I am of the view that the Cabinet Secretary read everything that crossed her desk. The Cabinet Secretary, or her private secretary, would then discuss appropriate submissions with me. She would often raise issues with me, request further information and suggest alternative approaches. The Cabinet Secretary and I were working together to make sure she got the best advice possible to inform her decision-making.

Ventilation issues on the radar

19. I have been shown a letter dated 25 January 2019 from Paul Gray, who was the DG at the time, to all NHS Chief Executives **(A35270542 – Letter from DG Health & Social Care and CE NHSScotland to NHS CEs setting out a set of actions about an ongoing incident (Cryptococcus infections) in QEUH – 25 January 2019, Bundle 4, Page 8)** and asked that assurances were sought from Chief Executives around ventilation systems in operation. This letter was issued before I took up the role of Chief Executive of NHS Scotland and DG of Health and Social Care. I would observe, however, that my experience of working within the NHS is that it strongly benefits from a number of national networks. The Strategic Facilities Group (SFG) is one of many such networks where NHS directors are brought together with counterparts in the Scottish Government to discuss emerging issues.

From my reading of this document, the SFG appear to be concerned about data coming out of the Queen Elizabeth University Hospital (QEUH) and wanted to make sure that every health board had an awareness of the data.

20. Each health board is a statutory authority that has accountability for delivering capital projects. I would infer from reading this document that SFG appeared to be aware that issues arose concerning the water supply. As such, SFG were seeking assurances from each health board and had asked Health Facilities Scotland (HFS) to co-ordinate the responses. These assurances included confirmation that all critical ventilation systems should be inspected and maintained in line with SHTM 03-01 **(A32353809 – SHTM 03-01 Part A - Ventilation for healthcare premises - Design and Validation – February 2014, Bundle 13, Volume 3, Page 951)**. I would also infer that, because he was writing directly to health boards, the Chief Executive of NHS Scotland and DG of Health and Social Care was taking the issues emerging from QEUH very seriously.

21. I have been asked if I can explain the role of HFS in the assurance process outlined in the letter. The NHS has a number of national bodies with particular expertise. In my own experience, significant expertise resides in NHS National Services Scotland (NHS NSS), which is a large national board with various divisions, each of which have professional and technical expertise. NHS NSS had a network of all of the Directors of Facilities and Estates, across Scotland, who have technical expertise and assist with the drafting of the technical guidance. HFS have infection control expertise and can also draw upon the expertise in that area from Health Protection Scotland (HPS) and health boards, so they are the points of expertise that we would place reliance on. This may well have been why the DG looked to HFS to co-ordinate the responses.

22. I have been asked if the Scottish Government was relying on HFS to ensure compliance with applicable guidance at this point and throughout the project. It was not the role of HFS at that time to ensure compliance. They were there to advise and support.

The responsibility for ensuring compliance lay with the statutory authority for the project, which was NHSL. That is why you see the Chief Executives of health boards being asked to confirm their boards' compliance. Each health hoard has a responsibility to make sure that it is obtaining professional technical advice and has the systems in place to deliver as required. HFS can be drawn-upon by health boards for that advice.

23. If we look back 10 to 15 years or so, the then Common Services Agency, which was the predecessor of NHS NSS, had a more formal role in projects across Scotland. By the time of the RHCYP/DCN project, the primary responsibility lay with health boards to set up a project structure, obtain guidance from HFS and assure themselves that matters were proceeding properly.

24. I have been asked if I received any briefing update regarding RHCYP/DCN when I took up the post of interim DG in February 2019. I was made aware of SA1 and that a number of outstanding matters covered in SA1 required to be completed before the hospital could open. I was also aware of NHSL's intended opening date on 9 July 2019 and that plans were in place for migration from the existing facilities to the new RHCYP/DCN facilities. I understood that NHSL were working hard within a tight timetable to meet the migration date of 9 July. It was my understanding that the indications the Scottish Government were receiving from NHSL at that time were that the project was on track and that NHSL were working hard within a tight timetable to meet the opening date of 9 July 2019.

25. The Scottish Government has a responsibility for the whole of the capital programme in Scotland, so I would expect my Directors only to raise any significant problems with me. These projects were being managed on a day-to-day basis by NHS Health Boards, not by the Scottish Government.

There are always issues with all capital projects, so I would expect my Directors to take a view on whether those issues are being properly addressed by the NHS health board concerned and what level of confidence existed that the issues would be resolved. If there were significant issues arising, such as cost overrun or differences of clinical view, I would expect to be informed. I had the practice of having regular one-to-one meetings with each of my Directors; and monthly meetings with NHS Chief Executives. Until the call I received on 2 July 2019, there were no issues of this magnitude being reported to me in relation to the RHCYP/DCN project in the weeks before the planned opening on 9 July 2019.

26. I am certain that the first time I heard about the 'critical care issue' was when I received a call from the Chief Executive of NHSL on Tuesday 2 July 2019. As far as I am aware, the critical care incident was not known to NHSL until the preceding Friday, 28 June. I am sure that it was not known about within the Scottish Government until Tuesday 2 July 2019.

Reporting of Critical Care issue to Scottish Government on 2 July 2019

27. I first became aware of the issue within the Critical Care Unit at RHCYP when a message came through to my private office early that afternoon advising that the Chief Executive and Chair of NHSL wanted to have an urgent conversation with me. That does not happen very often. John Connaghan (the then Chief Performance Officer within the Scottish Government's Health & Social Care Directorate) was with me when I took the call. The Chief Executive of NHSL outlined that NHSL had come across an issue with the Critical Care Unit at the RHCYP. In short, they could not get 10 air changes per hour within the Critical Care Unit. NHSL were extremely concerned about it and wanted us to know that this had been uncovered. The ability to resolve the issue by Friday 5 July, in time for the start of the planned migration, was going to be very challenging but they were trying to identify a workaround to the problem.

28. NHSL were, understandably, most concerned about the situation because many thousands of patients, all of whom had been told that their appointments, operations and procedures were going to be in the new hospital, were going to be affected, along with their families. Hundreds of staff had packed boxes and were ready to move; and a huge amount of work had gone into that. As such, it seemed reasonable to me for NHSL to consider, when they first found out about the situation, whether there was a potential for any workaround. There was nowhere near enough data available on 2 July 2019 to reach a concluded view on whether the move could continue as planned.

29. Upon being told this information it was clear to me that the Cabinet Secretary needed to be told immediately. My Directors (including the Chief Medical Officer, Chief Nursing Officer, Director of Workforce, and others) and I would need to quickly obtain a better understanding of what was going on, so we stood up the Health Resilience Unit. This Unit is a distinct resilience function, available to coordinate intelligence and information coming from NHSL to the Scottish Government. In addition to understanding the position ourselves, we had to be able to brief the Cabinet Secretary who, in turn, would have to brief the First Minister and manage the parliamentary process. Please see available emails (**A41022820 – Email from Cabinet Secretary for Health and Sport to Michael Healy on RHCYP delay and update on work undertaken - 8 July 2019, Bundle 7, Volume 1, Page 181),** explaining that "Your officials will now operate under a health resilience response…"

30. The Health Resilience Unit was engaged in the 'emergency' response to the information that came to light on 2 July 2019. The Unit 'stood-down' on 18 July 2019, by which point the Scottish Government had implemented the decision of the Cabinet Secretary (see below) and further measures to address the situation had been put in place. See (**A41225838** – **NHS Lothian – Edinburgh Children's Hospital – Action List Closure - Bundle 7, Volume 2, Page 10**) which indicates they were stepping down at that time.

31. I have been asked by the Inquiry about a second telephone call from Mr Davison at 5.30pm on 2 July. I do not recall this telephone call taking place. It was, however, over 4 years ago, since which time I dealt with the early part of the Covid pandemic and then retired. It may be that this call did not go ahead due to the rapid developments at the time and the multiple discussions that were taking place at Director level. Things were moving quickly, with information coming in constantly, including from NHSL, all of which was being collated.

32. I am asked why there are no records, minutes, or both, narrating the content of the calls on 2 July. In dealing with matters on 2 July 2019, and indeed the following days, I was dealing with the emergency situation that presented on that unexpected call on 2 July 2019, my focus was on finding out what was going on and how best to manage the situation. The outcome of discussions were encapsulated in submissions and emails, including the email dated 2nd July 2019 at 1653 hours from Alan Morrison to the Cabinet Secretary, which I was copied into **(A41020525- Email from Alan Morrison to Cabinet Secretary for Health and Sport attaching briefing on an emerging issues from NHS Lothian - 02 July 2019, Bundle 7, Volume 1, Page 37)**.

33. I cannot recall at what stage the Cabinet Secretary was actually told about the issue in the Critical Care Unit, but I am sure that she would have been told verbally before the 1653 submission. That would have been the first written briefing that went to her outlining the issues.

34. Within this email was a short-written brief prepared by Alan Morrison, regarding the issue with the air change rates in the paediatric Critical Care Unit. The briefing gave the background, the derogation and NHSL's assessment. Questions that we were asking and urgently seeking answers to at that point included:

- What can be done with the existing ventilation plan to improve on it?
- Is there an interim fix?

- Can a permanent solution be installed in the new building once it is occupied?
- What would be the level of disruption and loss of capacity?
- What loss of capacity can be tolerated, given the paediatric intensive care capacity is coordinated across Scotland?
- Any delay to the opening of the new RHCYP/DCN facilities would have a major knock-on impact, so how long is it going to take to resolve the issues?

35. When first informed of the issues within the Critical Care Unit, I was hugely concerned; the project had taken decades to plan and thousands of patients and families were going to have their plans disrupted. The impact on them and staff would be huge. There would have been no hesitation in informing the Cabinet Secretary of the situation. My office was literally a few yards from hers, so I expect that I would have gone round to the Cabinet Secretary's private office and told her private office staff (I cannot, at this distance, recall specifics).

36. I have been asked by the Inquiry about my expectations as to when I should have been informed about the critical care issue coming to light within NHSL, given the proximity of the migration date. I would expect to have been told by NHSL as soon as they were aware of the problem and understood it. From what I have read after the event, the issue came to light on Friday 28 June 2019 and NHSL were then immediately working to understand the issue. I understand (again from information I read after the event) that NHSL arranged for a number of meetings to take place during the course of Monday 1 July 2019. The Chief Executive of NHSL, Tim Davison, had been on leave and returned to work on Tuesday 2 July 2019. It was immediately escalated to him that day. Tim Davidson's immediate reaction was that the Scottish Government had to be informed. As above, I was informed on 2 July 2019.

37. I have been informed by the Inquiry that NHSL may have become aware of the issue within the Critical Care Unit as early as 24 June 2019. I do not know if this is the case.

38. Whilst I did not understand, as at 2 July 2019, what had gone on within NHSL that had led to this situation, my immediate focus had to be on managing the emerging crisis. All of my officials were fully engaged on trying to find out what the immediate situation was and what needed to be done to deal with it. NHSL were working very hard trying to establish what had happened and what needed to be done and were feeding information back to us. My team did not want to additionally burden NHSL with issues that could be considered at a later date.

39. The unfolding situation required urgent action by my whole senior team within the Directorate. John Connaghan played an important role in those first days, because he dealt with the performance management of the health boards. John regularly discussed performance issues with the NHS Chief Executives on my behalf, so he was involved from the outset. Christine McLaughlin and Alan Morrison were also key, given their finance roles in the capital plan. The Chief Medical Officer and Chief Nursing Officer's directorate were also involved (initially the Deputy Directors in each directorate due to the Chief Medical Officer and Chief Nursing Officer both being on leave), as was Shirley Rodgers, given the workforce implications. We worked as a team by getting in touch with our counterparts in NHSL to try to find out exactly what the issues were.

Events of 3 July 2019

40. I had a one-to-one meeting with the Cabinet Secretary on 3 July, at which I updated her on the RHCYP/DCN situation. We had one-to-one meetings every week, which provided an opportunity for the Cabinet Secretary and I to discuss current issues, prospective plans and what requirements she had. This particular meeting was one of my regular scheduled one-to-one meetings with the Cabinet Secretary and took place at Atlantic Quay in Glasgow.

I cannot recall whether or not one of her private secretaries was present at the meeting or whether any notes were made by her private office in relation to this meeting. I cannot recall any occasion when I had a one-to-one with the Cabinet Secretary where a minute was taken. It is important to differentiate between what is a formal meeting and what is a one-to-one. I had regular one-to-ones with all of my direct reports and have done that throughout my career.

41. Having been asked again about the absence of minutes, I can only observe that I appreciate that documentary evidence, such as minutes of real-time conversations (even in non-formal settings), would provide the Inquiry with a better understanding of matters being discussed between Scottish Government colleagues. We were managing a crisis situation at that time and were not, then, thinking about the level of after-the-fact scrutiny brought by a public inquiry. The migration to the new hospital was due to happen in a few days. We needed all available resource to be fully applied to finding out what was going on and processing all information coming through. The context within which we were operating was one of having limited time and resource available to tackle many urgent activities. This occurred during the first week of the school summer holidays and the Scottish Parliament was in recess, meaning that resources were already depleted due to annual leave; and, crucially, it was just days before the planned opening of the RHCYP/DCN. Within this context, I did not regard minuting all conversations that took place as a high priority at that time. The Inquiry will, of course, form its own view.

42. I cannot recall the specific details of my meeting with the Cabinet Secretary on 3 July 2019, however I would certainly have informed her of progress being made and we would have discussed the many questions arising from the issues raised in the email from Alan Morrison on 2 July 2019 **(A41020525- Email from Alan Morrison to Cabinet Secretary for Health and Sport attaching briefing on an emerging issues from NHS Lothian - 2 July 2019, Bundle 7, Volume 1, Page 37)**.

43. Alan Morrison sent me an email on 3 July 2019 regarding a meeting he attended with NHS NSS and NHSL **(A41020637 - Email from B Elliot (on behalf of DG Health & Social Care) to Malcolm Wright summarising the main risks associated with the move of ICU to the new RHCYP – 3 July 2019, Bundle 7, Volume 1, Page 48)**. I have no reason to disagree with Alan Morrison's account in this email. This encapsulates the main risks that were being discussed at that time and, from an assurance point of view, we knew that we wanted the national experts at NHS NSS to be involved immediately.

44. NHS NSS has a wealth of national expertise on a whole range of issues. They employ their own staff, co-ordinate all of the detailed technical guidance and memoranda and also have links with each of the health boards, including Directors of Facilities and Capital Planning. Through HPS, NHS NSS also have links into the Directors of Public Health and the whole infection control and infection prevention network, including virologists and microbiologists who will be advising on the technical requirements in order to minimise risk to patients.

45. The staff at NHS NSS would be able to provide expert insight into what had happened and the risks involved. They could draw on medical professional advice and buildings-related advice before presenting their advice to NHSL and the Scottish Government. The offices of the Chief Medical Officer and Chief Nursing Officer would also have been providing their input (although the Chief Medical Officer and Chief Nursing Officers themselves were both absent from work when the critical care issue first came to light, their deputies and teams were engaged).

46. From reading this email I can see that the consensus of those attending the meeting was that the safety of the patients would be best served by delaying the move and modifying the ventilation in the new building before moving patients. I agreed with that position.

The position is reinforced by the email that Tracey Gillies sent to Tim Davison on 1 July 2019, **(A44265139 - RHCYP critical care ventilation issues dated 1 July 2019, Bundle 13, Volume 3, Page 1140)**, where she discusses the Institute of Occupational Medicine (IOM) testing of the ventilation and provides a synopsis of the issue. In short, NHSL had tested the four bedded and single rooms and found that the air changes do not meet the required standard per SHTM 03-01. The email also discusses the use of a larger plant to deliver the air changes, as the current plant was not adequate. She asks the question, "Is this fit for purpose?", and then, "If occupied now, there is a risk to patients." Here we have NHSL's Medical Director informing NHSL's Chief Executive that it was unclear whether the space was fit for purpose and raising concerns about patient safety if the move were to go ahead as planned. In my view, if a health board Medical Director raises these issues, that requires very careful consideration.

47. Within the email, Tracey Gillies states that if the building is occupied now then there is a risk to patients, visitors and staff of airborne virus transmission and a decant would probably be required to remedy issues. There are significant risks involved in that and it would likely diminish national capacity. The final bullet point on the email states, "If not occupied now, the move needs to be postponed." This email provides a summary of the advice of NHSL's Medical Director to NHSL's Chief Executive. I think it complements what Alan Morrison says within his email. It appears to me that people realised very quickly that the problem was not going to be amenable to a 'quick fix' and there was a potential risk to patient safety.

48. On 3 July 2019 I received an email from Tim Davison **(A41020529 – FW_ RHCYP _DCN Commissioning_ ventilation dated 3 July 2019 – Bundle 13, Volume 3, Page 1141)** where he provided a summary and set out 4 potential options. My reading of this is that Tim was taking advice from NHS NSS and his professional advisors and was using this correspondence to set out potential solutions. I am aware there was a constant dialogue between the Scottish Government and NHSL over 2 and 3 July 2019.

I have been asked if, at the time of Tim sending this email with his preferred option, he may have been under the impression that NHSL would be making the final decision on how to proceed. I cannot say for certain what was in Tim's mind at this point. The key action for me was to get this email in front of the Cabinet Secretary prior to her meeting with all of her key advisors on 4 July 2019. I would not have immediately responded to this email because an email of this importance and complexity needs a very considered response from the Scottish Government and I certainly would not have replied without the full approval of the Cabinet Secretary.

49. I have been asked by the Inquiry if the Scottish Government gave any indication to NHSL that some services would move as planned. I would be surprised if that was the understanding of anyone in the Scottish Government as we had been in information-gathering and no decision had been made prior to 4 July 2019. I am aware that staff were exploring all possible options but would be surprised if any official from Scottish Government had said that any particular option would be alright because they would not have had authority to do that without sign off from the Cabinet Secretary.

50. I have been told by the Inquiry that NHS NSS were under the impression that some services would move as planned, however, I would want to know where they received any such information from. To my knowledge, no one within the Scottish Government could have made a decision to endorse option four and the only person who had authority to make that decision was the Cabinet Secretary. There was no agreement given by the Scottish Government regarding the partial migration of some services on 9 July 2019 and to my knowledge no 'U-turn' in decision-making.

Events of 4 July 2019

51. On 4 July 2019 I met with the Cabinet Secretary and other ministerial advisors in order to discuss the information by then available in respect of the issues at the Critical Care Unit at RHCYP/DCN.

Given that the RYCYP/DCN had been scheduled to open on 9 July and the move was due to begin over the few preceding days, the requirement for a decision to be made as to what should happen was of the utmost urgency. There were a range of officials in the room; from memory those officials included John Connaghan; Gregor Smith (Deputy Chief Medical Officer); Diane Murray (Deputy Chief Nursing Officer); Shirley Rogers (Director of Workforce); Christine McLaughlin and Alan Morrison (Director of Health Finance and her Deputy) together with representatives from the Scottish Government health communications team and health resilience. There may have been others who I am not able to recall at this time.

52. We all went into the meeting with a strong sense of the seriousness of the situation and that we were going to give the Cabinet Secretary the very best advice we could, based on the written reports available and conversations we had held with NHSL, HFS, HPS and others. The Cabinet Secretary chaired the discussions, making sure she listened to all in attendance and asked for their views and opinions. She took that advice onboard and made the decision to halt the move. The outcomes of the meeting were encapsulated in my email to Tim Davidson **(A35827763 - Email from Malcolm Wright to Tim Davison confirming that the Cabinet Secretary has taken the decision – 4 July, Bundle 7, Volume 1, Page 79)**.

53. The prime consideration during our discussions at the meeting was patient safety. I think the key concern was that we might be putting patients at risk if they were to move at this stage. I think everyone in that room was well aware of emerging issues at the QEUH; of having a brand-new hospital built, people moving in and issues then emerging in terms of infection control. We had to think about the risks associated with the move proceeding and something then happening to any of the patients – not only harm to the patients concerned, but also the wider loss of public and staff confidence in the facilities.

54. The experiences of and lessons being learned from the QEUH made us conscious that we had to be very careful about what action should be taken. We could not risk making the decision to open the hospital and then later discover that there were potential issues that we could have mitigated against by pausing, that harmed patients. In terms of understanding the scale of the problem with the building, we were concerned that there might be further issues that were not yet known of, so we could not confidently, at that stage, identify the solution or the consequences (including cost) of such a solution. Similarly, we could not, at that point, properly understand the disruption that any solution would cause, including whether any solution could be implemented with patients in situ. There needed to be assurance that the new building would be fully compliant with relevant standards. More work also needed to be done in order that we could know what the knock-on impacts would be for other services, including whether there would be a loss of national capacity. There was also the contract structure, which might impact upon the cost and timeframes of potential solutions, to consider. You cannot properly consider all of these complex variables within 48 hours.

55. 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 to take time to get this right.

56. I have been asked by the Inquiry what advice I gave to the Cabinet Secretary at the meeting. I have worked in paediatrics and child health for a large proportion of my career and when I worked at Great Ormond Street, there was a sign above the door that says, "The child first and always.". If you put children (patients) first and work back from that, you do not put people in harm's way. I believe that very strongly. The Cabinet Secretary also instinctively immediately thought of the individual, the patient, and what it would mean for them. Quite simply, you do not expose patients to a situation where nobody fully understands the risk.

57. It was also clear already that a significant amount of public money would have to go into dealing with this situation; and that public money would have to come from the health portfolio budget. This would, inevitably, mean that other projects in Scotland would be impacted, but I would not countenance a position that did not put patient safety first.

58. A letter was drafted following the meeting, which I emailed to Tim Davison, the Chief Executive of the NHSL **(A35827763- Email from Malcolm Wright to Tim Davison confirming that the Cabinet Secretary has taken the decision – 4 July, Bundle 7, Volume 1, Page 79)**. This letter reflected the outcome of the meeting that day with the Cabinet Secretary and set out the Cabinet Secretary's decision to halt the move. I have been asked by the Inquiry what "further information" was being referred to within this letter. I believe this was reference to information provided by Alan Morrison in his email of 3 July 2019 **(A41020637- Email from B Elliot (on behalf of DG Health & Social Care) to Malcolm Wright summarising the main risks associated with the move of ICU to the new RHCYP - 3 July 2019, Bundle 7, Volume 1, Page 48)** and other information received since 2 July 2019 from HFS, HPS and via my Directors, who had been involved in a number of meetings, all of which was ultimately discussed at the meeting with the Cabinet Secretary on 4 July 2019 and upon which the Cabinet Secretary based her decision.

59. A number of actions required of NHSL, which had been raised by the Cabinet Secretary following advice from her officials, were set out within this letter. This letter was issued under the authority of the Cabinet Secretary. It had been very carefully drafted and we were collectively content that it summarised the Scottish Government's position towards NHSL and what it was required to do.

60. Again, surprise has been expressed to me by the Inquiry as to the lack of formal minutes for the meeting of 4 July 2019. I would refer to my previous observations as to the context within which we were operating.

Those in attendance would have been taking their own notes and there would be a lead official who was responsible for drafting the letter. The letter that I have just referred to was the output of that meeting and serves as a record of what was decided. The letter would have been cross-checked with all of the directors, including me, and cross-checked with the Cabinet Secretary's private office in order to confirm that it encapsulated what the Cabinet Secretary had decided. I think this letter captures the decision and actions that were agreed.

61. I have been asked by the Inquiry why NHSL's preferred solution was not considered an appropriate way forward in terms of migrating some unaffected services to those clinical areas. My view is that it did not account for the other issues that may emerge. The Cabinet Secretary, correctly in my view given the circumstances of late discovery of such a serious issue, wanted external assurances from HPS and HFS that the building infrastructure was safe and those assurances had not and could not have been given by 4 July 2019.

62. As we started to move forward there were other actions taken, such as the commissioning of NHS NSS to do reports and the formal commissioning of KPMG to look at the governance and the audit of the project. I also contacted the Auditor General because they would be looking at this project and the extra costs incurred as a result of the delay. The Cabinet Secretary would need to brief Parliament, the Health and Sport Committee, and the Public Audit Committee. I would need to brief the Permanent Secretary.

Communications

63. The media and the press had also become aware of the situation and the Cabinet Secretary took the decision that she wanted to authorise all communications to patients and staff. The letter of 4 July 2019 required preparation of a communication plan and for all communications to be cleared by the Scottish Government.

In a crisis situation such as this one, you need an alignment of communications to ensure a consistent message is put forward by NHSL and the Scottish Government. The Scottish Government's health communications team worked closely with NHSL's communications team.

64. The Inquiry has asked for my knowledge of the briefing sent to the First Minister by the Cabinet Secretary on 4 July 2019 **(A41444207 - Briefing for First Minister on RHCYP – dated 4 July 2019, Bundle 13, Volume 3, Page 89)**. I cannot comment beyond what I can read in the briefing. I am not aware of the First Minister having any involvement with the project in terms of decision-making.

Events of 5 July 2019

65. On 5 July 2019 I received an email from Tim Davison **(A35827764 – Email from Tim Davison to DGHSC UPDATE ON Transport, Telephone Helpline, Direct communication to individual patients and Communications – 5 July 2019, Bundle 7, Volume 1, Page 96)**. This email provided updates on the matters we had directed NHSL to put in place, such as transport, a telephone helpline and communications. We thought it was important for NHSL to have transport in place for those who presented at the wrong hospital and a telephone helpline for the public who had concerns; that they contact individual patients to provide updates on treatment; and a communications plan had been established.

66. The relevant Scottish Government Directors were working with their counterparts in NHSL throughout this period. The Cabinet Secretary and I wanted to avoid a situation whereby all of the management capacity at NHSL was being used to deal with this issue, as this could have a detrimental impact on other departments. We were very mindful of the capacity and the resilience of the senior team within NHSL.

67. There were a number of different streams of action that flowed from the events of 2 to 4 July 2019 and we had assistance from colleagues in health resilience in co-ordinating these. This work included commissioning the NHS NSS report, commissioning KPMG report to conduct their internal audit and establishing regular Incident Management Team (IMT) meetings with NHSL.

Events of 8 July 2019

68. On 8 July 2019 I received an email from Tracey Gillies, NHSL's Medical Director **(A35827765 – Email from Tracey Gillies to Callum Henderson et al providing a response– 8 July 2019, Bundle 7, Volume 1, Page 173)**, following the first IMT meeting regarding the RHCYP/DCN issues. Tracey was responding to questions that I had asked concerning the issues raised and was able to provide an informed medical opinion. One of the questions asked was if the derogation to change the air circulation from 6 to 4 to meet the terms of SA1 had been approved by HFS and HPS. The response to this question from Tracey was that it had never been NHSL's understanding that the derogations agreed during the project required formal approval. She advised that derogations agreed as part of the Settlement Agreement had been discussed with Scottish Government and Scottish Futures Trust (SFT) colleagues; and that technical advice on the derogations had come from NHSL's technical advisors to the project, infection control, clinical colleagues and facilities.

69. I asked if, NHSL could provide a new design plan for air ventilation that would meet standards and be cleared by HPS and HFS within the next 2 weeks. Tracey advised that it would not be completed within that timescale and, as the project was under NPD, any changes would require technical sign-off from lenders.

70. NHSL's reliance upon the advice of its technical advisers as to the change in air circulation is important to note. The Scottish Government does not have the depth of technical professional expertise available to advise on such matters on individual projects, nor should it as its role is to manage the whole of the capital programme for Scotland. Nor does the Scottish Futures Trust, in my understanding, have expertise available within their organisation to provide such advice for individual projects; rather it plays an important role in terms of the overall setup of the structures.

71. I have been asked if the Scottish Government might itself have approached NHS NSS to provide that relevant technical opinion on whether derogations to the air circulation were appropriate. I would not expect the Scottish Government to approach NHS NSS in this particular situation. The statutory body responsible for running a capital project is the health board; not the Scottish Government, SFT or NHS NSS. I would note again that NHSL sought assurance from their contractors, who in turn sought assurance from their contractors and advisors and that assurance was provided. Assurances were being provided to the Scottish Government that the RHCYP/DCN project was on track to open as planned on 9 July 2019, so I cannot see there being a trigger for the Scottish Government to involve NHS NSS.

72. The responses within this email from Tracey Gillies further informed the thinking of the Cabinet Secretary. The initial fundamental problem was the 10 air changes per hour, however, it was becoming apparent that further issues were being identified that also needed to be resolved.

73. The issues at the QEUH and RHCYP/DCN very much influenced the thinking about the Centre for Excellence, which became NHS Scotland Assure: the health board, as the accountable body, should have a sign-off from an external expert body at different points in the process to say whether work meets the necessary standards.

74. On 8 July 2019 I visited Tim Davison to better understand how he was dealing with the issues and how NHSL was managing. I discussed with him about the level of seriousness with which the Cabinet Secretary viewed the matter and how he might prepare for his upcoming meeting with the Cabinet Secretary. It was an informal meeting and therefore no minutes were taken.

75. The Inquiry have asked me if I was aware of the DCN migration/feasibility study that was carried out on 8 July 2019, where a workshop was held and chaired by Fiona Halcrow, Project Manager (NHSL Clinical Support). The purpose of the study was to discuss whether the DCN could move safely as a stand-alone service into the new building. This matter was raised in the briefing to the First Minister of 5 July 2019 **(A44264335 - Edinburgh Children's Hospital – Note from Cab Sec to FM – 5 July 2019, Bundle 13 Volume 3, Page 1144)**, where it highlighted that delay to the migration of DCN services was not risk free and that staying at the existing site posed risks. It is stated that*, "*there [was] probably a good clinical case to prioritise migration of the [DCN]*".* I was aware of this study and have been asked how this is reconciled with the notion that the RHCYP/DCN migration was delayed in the interests of patient safety and care. I believe there was an understanding that we could migrate DCN before the RHSC, that the DCN move was discrete and once we received the assurance that this building was safe, then that move could go ahead.

76. We knew the risks that pertained at the existing sites (they were old and being replaced for that reason) and the Cabinet Secretary made it clear that if resources were going to be needed to further mitigate those risks, then those would be provided. We immediately made that offer to NHSL. This was preferable to placing patients and staff into an unknown situation.

77. I believe the public in Edinburgh have always appreciated the RHSC and the staff there. There was public confidence that the staff were delivering excellent healthcare from the existing facilities.

Our assessment was that providing continuing and increased support to mitigate risks at existing sites was a more secure proposition than moving patients and staff into a new situation where there were new risks, which at that time were not fully quantified or risk assessed.

78. My view is that the cautious approach we took by postponing the move and supporting risk mitigation at existing sites was the correct approach. The alternative was to move earlier but there was an infection control risk and other patient safety concerns. In turn, this could impact public confidence and amplify the problem.

Escalation to Level 3

79. On 12 July 2019, consequent to the emergence of the issues at RHCYP/DCN, a decision was taken to escalate the NHSL to level 3 of the NHS Board Performance Escalation Framework **(A41263551 – Letter to Tim Davison, copying in Brian Houston, from Malcolm Wright – 12 July 2019, Bundle 7, Volume 1, Page 339)**. This escalation is the responsibility of the DG, acting on advice from the HSCMB, who met on 10 July 2019 **(A41029115 – HSCMB-85-2019-10 July 2019-Board Performance Escalation Framework NHS Lothian – OFFICAL SENSITIVE – 10 July 2019, Bundle 13, Volume 3, Page 683)**. This was not a Ministerial decision, however I would have spoken to the Cabinet Secretary about the decision.

80. NHSL had been escalated to Level 3 as it faced a wide range of challenges in light of the issues with RHCYP/DCN. The HSCMB had concerns that this would place significant pressure on the leadership capacity of NHSL and could impact across other services if their sole focus were the issues at RHCYP/DCN. The decision was made to provide them with a tailored package of support; and John Connaghan was to work with the Board to create a single recovery plan.

81. The NHS Board Escalation Framework (the Framework) provides a relationship between Scottish Government and statutory bodies, where concerns can be raised with relevant health boards. The ideal position is to have all health boards at the lowest level of escalation; with the worst-case scenario being escalation to Level 5. In this worst-case scenario, the Scottish Government would be directly running the health board. All health boards move up and down the escalation levels of the Framework. The level of escalation will determine the level of support provided to a health board. This is important for two reasons: firstly, the Framework is used as a vehicle to allow for resources to be directed to where they are needed; and secondly, it provides transparency to each health board as to why resources are being directed to a particular area.

82. The HSCMB constantly look at the criteria of the Framework and review the level at which each health board is placed. Escalation and de-escalation between the lower levels of the Framework is a frequent occurrence. If a health board is escalated to Level 4, however, then an improvement team would be sent in and a turnaround director would be appointed. Escalation to level 4 and 5 are significant events. The nature of the Framework means there will be varying levels of control by the Scottish Government over each health board, as they move to different levels within the Framework.

83. A paper **(A41029115 - HSCMB-85-2019-10 July 2019-Board Performance Escalation Framework – NHS Lothian – OFFICAL SENSITIVE -10 July 2019, Bundle 13, Volume 3 Page 683)** was produced for NHSL, outlining the reasons why it had been escalated to Level 3 and providing for tailored support to be provided in order to scaffold the formal recovery plan that we were seeking from the Board.

84. As part of the Framework escalation to Level 3, an Oversight Board was established. The scope of work of the Oversight Board is set out within its Terms of Reference **(A44284514 - NHS Lothian RHCYP Oversight Board_ToR– July 2019, Bundle 13, Volume 3, Page 1149),** but ultimately it was to oversee the successful completion of the project.

The Terms of Reference were drafted by Christine McLaughlin and would have been signed off by me and, ultimately, the Cabinet Secretary.

85. The Oversight Board membership brought together a variety of skills, technical expertise and significant experience, including clinical expertise with Fiona McQueen (CNO); Catherine Calderwood (CMO); Tracey Gillies (Executive Medical Director NHSL); Prof Alex McMahon (Nurse Director NHSL); and we also had Peter Reekie (Chief Executive SFT), Susan Goldsmith (Director of Finance, NHSL) and Christine McLaughlin herself. The role of the SFT, for example, was important in terms of bringing experience of contract structures. The Oversight Board reported to the Scottish Government, providing an important source of advice to the Cabinet Secretary, who received every set of Oversight Board papers.

Events of 18 July 2019

86. On 18 July 2019, the Cabinet Secretary, the CMO and I, visited the RHSC at Sciennes, where we met with the Chair and Chief Executive of NHSL. The purpose of this visit was to meet with patients and staff, and to communicate to them directly the decision the Cabinet Secretary had made and why she had made it, and she wanted to hear the views of patients and staff.

87. On arrival we had half an hour with the Chair and Chief Executive of NHSL. This provided an opportunity for the Chair and the Chief Executive of the accountable board to inform the Cabinet Secretary of what had happened and why it had happened. This was first time that they had met following the critical care issue being identified. The Chief Executive spoke in detail about the project, including its structure, its complexity, what issues had been found and what they wanted to do.

88. Following this meeting, we met with staff. The Cabinet Secretary provided them with the rationale behind the decision not to open on 9 July 2019, listened to their concerns and reassured them of the Scottish Government's intention to do what was needed to support them in staying at the RHSC at Sciennes for longer than had been anticipated.

89. We then split up and I spoke to a number of staff to get their views and opinions on the situation. From these discussions, I found that there was a profound sadness and distress from staff, however, at no stage did staff tell me the decision was wrong. Rather, their focus was on what we needed to do to support staff and patients staying at the RHSC at Sciennes for longer than anticipated. There were a number of risks that had to be mitigated, including maintenance that had not been carried out because they thought they were leaving. Issues such as these required extra resources to ensure the patient environment remained safe.

90. We had a similar experience on our visit that day to the DCN facilities at the Western General Hospital.

NSS Review / KPMG Report

91. I have been asked about my involvement in instructing NHS NSS to carry out a review of the RHCYP/DCN (**A41213257 - NSS Report – 9 September 2019, Bundle 7, Volume 3, Page 373)**. I cannot recall having any direct involvement in the formulation of this instruction. I was kept informed during this process and may have had a conversation with the Chief Executive of NHS NSS concerning the review and the time frames involved, but do not have a clear recollection.

92. A high degree of reliance was placed upon NHS NSS (for good reason), as they either had or had access to expertise in respect of these highly technical issues. This is why NHS NSS was approached to report upon the issues arising at RHCYP/DCN.

93. NHS NSS will be able to speak to their own report, but it highlighted issues with management and assurance and technical issues related to ventilation, water, drainage/plumbing and consequent infection control risks. It was clear that the issues extended well-beyond the initial reported issue regarding air changes in the RHCYP critical care unit.

94. On 12 July 2019, KPMG were instructed to conduct an independent audit of the governance arrangements in place for the RHCYP/DCN project **(A32512397 – 4.5 KPMG Report - Independent Assessment of Governance Arrangements – September 2019, Bundle 13, Volume 3 Page 1153)**. Again, I had no personal involvement in the formulation of the instruction of this report, but I would have seen the terms of reference and they would have been signed off by the Cabinet Secretary. I believe that Christine McLaughlin would have been involved in the drafting of the terms of reference. This process and the NHS NSS review were very much Director led, but sign-off ultimately fell to the Cabinet Secretary.

95. The KPMG audit sought to understand the system of governance. The report was clear that it could not and did not seek to personalise, which I consider to have been appropriate, given the number of people, companies and public bodies involved. In my view, the audit by KPMG principally sought to identify what processes of assurance were in place for NHSL and why fundamental issues had not been picked up by the governance systems in place.

96. Following the publication of the reports, I discussed some of the findings with Christine McLaughlin **(A41232875 – Email from Christine McLaughlin to Malcolm Wright - 9 September 2019, Bundle 7, Volume 3, Page 366)**. The report by KPMG identified the role of the environmental matrix in the process, which appeared to be central; the contract requirements; and what was described as a confused landscape. The report identified that what began as human error was likely to continue throughout the project, yet there were a number of opportunities where it could have been identified and rectified but was not. Had there been a point in SA1 where an independent assessment against standards was done, I believe the issues could have been identified.

97. The NHS NSS review and subsequent report did provide us with assurance; and also reassurance in that we had made the correct decision in delaying the move. The report revealed that there were further issues with the build than had been reported to us on 2 July and we would need to rectify those issues before we could finally allow patients and staff to move.

The Grant Thornton Report

98. I am referred to the Grant Thornton Report dated 12 August 2020 **(A32512442 - Grant Thornton Report –NHS Lothian Internal Audit Report – Report for the Audit and Risk Committee 31 July 2020 and the NHS Lothian Board, 12 August 2020, Bundle 10, Page 4) (The Grant Thornton Report))**. This was an internal report prepared for NHS Lothian. The report was shared with the Scottish Government in advance of publication and NHSL made clear that they would accept and action all recommendations and the Scottish Government expected all recommendations to be actioned.

Letter to Auditor General

99. On 19 July 2019 I wrote to the Auditor General **(A41232572 – Letter – AG-Lothian July 2019 (1) – 29 July 2019, Bundle 13, Volume 3, Page 1239)**, outlining the Cabinet Secretary's reason for the decision to delay the move to the new RHCYP/DCN facilities. The Auditor General is required to undertake an annual audit of the NHS in Scotland. The Auditor General will identify, during the course of the audit, significant issues that have arisen within the NHS in Scotland and specific issues within individual health boards. The Auditor General also conducts or oversees the audit of individual health boards. I considered that it was important, from a government perspective, as the accountable officer for NHS Scotland, that I make the Auditor General aware of the issues with NHSL. I understand that as a result of this, the audit of NHSL was brought forward and there was a specific audit carried out on the project. I think this audit was extremely helpful to everyone's understanding of what happened.

100. The Auditor General reports directly to the Scottish Parliament. I consider that it was entirely correct for me to formally inform the Auditor General, thus ensuring openness and transparency.

Escalation to Level 4

101. Following the publication of the NHS NSS report and the KPMG Report – Royal Hospital for Children and Young People: independent assessment of governance arrangements (the KPMG Report) on 11 September 2019, I concluded, on the basis of the scale and challenge in delivering the RHCYP/DCN, that NHSL should be escalated to Level 4 of the Framework in respect of the RHCYP/DCN project. This was outlined in a report for a meeting of the HSCMB **(A34931238 - NHS Lothian Escalation – 11 September 2019, Bundle 13, Volume 3, Page 1241)**. At that meeting, HSCMB's assessment was that a broader range of issues needed to be addressed before the building could be fit for occupation, and additional leadership capacity would be needed to do this.

102. Following the HSCMB meeting, I notified the Chair and Chief Executive of NHSL in writing of the escalation to Level 4 **(A44267042 - Letter – MW – B Houston and T Davison – NHS Lothian Level 4 Escalation dated September 2019 –Bundle 13, Volume 3, Page 702)**. The move to Level 4 allowed us to appoint a transformation director or project director, which led to the appointment of Mary Morgan as Senior Program Director.

103. Prior to her appointment, I believe Mary Morgan was carrying out the role of Director of Strategy, Performance and Service Transformation within NHS NSS. As the Senior Programme Director, she would be responsible for the actions required to ensure that the project facility was fit for occupation and report to the Scottish Government through the Oversight Board. I understood that she had excellent relevant experience as a director, was highly technical, professional and had a determination to get results.

Remedial Works/Phased Openings

104. Following the establishment of the Oversight Board, the Scottish Government continued to be intimately involved. Both the Cabinet Secretary and I had a high degree of interest in making sure the project was completed. In respect of remedial works or migration of services, those decisions were reserved to the Scottish Government as it involved further expenditure of public money. The Cabinet Secretary had made the decision that nothing was to move until it had her approval. We also wanted the assurance from NHSL, through the Oversight Board, that the decisions that needed to be made could be relied upon; and we put public money behind that in order to ensure the completion of the project.

105. I have been asked if I was satisfied with the rate of design development for the critical care solution and other remedial works. I would not use the word "satisfied". I believe it moved forward as quickly as it safely could. I was keen to see progress without undue delay but did not want to see anything not being properly done.

106. With the heavy caveat that I retired before the migration to the RHCYP took place, I have seen no evidence that the migration to the RHCYP/DCN facilities could have been carried out safely earlier. Importantly, not only did we need to get the technical solutions in place, but the logistics of the migration were extensive.

Reflections

107. I have been asked what actions, if any, would have mitigated the risk of the critical care issue leading to a blanket delay of the entire build. My major learning point related to what the Cabinet Secretary and I had discussed in relation to the Centre of Excellence. Within Scotland we have 14 territorial health boards of various sizes, with various critical mass of expertise.

All will, at some point, have construction projects running and, as an accountable officer within the Scottish Government, I would want external validation to give me assurance that all is satisfactory. The Centre of Excellence, which is now 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. That would be my key learning point as to what could have been done differently.

108. I have been asked how satisfied I was with NHSL's handling of matters following the discovery of the critical care issue. I would say they escalated it to the Scottish Government; they had a hugely challenging time; and they responded to us and worked with us through hugely difficult circumstances, not only for NHSL as a whole but also for individuals.

109. I have been asked if I was satisfied with the Scottish Government's handling of matters following the discovery of the critical care issue. I have considered this at length and my reflection is that I think that the Scottish Government responded quickly and decisively, putting patient safety at the forefront of decision making. It was an incredibly challenging time and I am proud of the group of Scottish Government Directors who came together in this crisis situation and worked constructively with NHSL and NHS NSS. We managed to navigate through the first few days of July 2019, when people were unsure what was happening, to the point of decision on the 4 July 2019 and then quickly moved into a position of putting in place a system of support for NHSL that allowed for the project to move forward; in turn, allowing for the safe opening of the hospital for patients and staff. I am very proud of the work that the Scottish Government and the team that I led did in addressing the issues that arose. In this crisis response there was not a culture of blame. Instead, we worked collaboratively to resolve the issues and make the situation better.

110. I have been asked what I think was the key factor that led to the Critical Care issue going unnoticed until days before the planned opening date.

There will be others more qualified than me who can explain this, however, it seems to me that one needs to look to the detail of SA1 and the Environmental Matrix as to why the critical care beds were not receiving 10 air changes per hour.

111. I have been asked by the Inquiry if there is anything that the Scottish Government could be doing to avoid such an issue in the future. Again, I look to the establishment of NHS Scotland Assure: having their expertise and the checks and balances in place, goes some way to addressing these issues. I do not think it is a remedy to say we need to build up a significant capital planning function within the Scottish Government. That is not what the Scottish Government is there to do. I think we have to rely on the statutory accountable bodies, which are the health boards; and we need to make sure that they have the wherewithal to do these projects with appropriate external checks and balances in place and for the Scottish Government to exercise an oversight. The role of the Scottish Government was to manage the overall finances and the overall capital plan. I do not believe the solution lies in setting up a large capital planning function within each health board or that the Scottish Government should be micromanaging individual capital projects (it is too far removed from these projects and does not have the capacity or the capability to do that).

Declaration

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