Scottish Hospitals Inquiry

Witness Statement of

Timothy Paul Davison

Professional Background

1. My full name is Timothy Paul Davison. I am currently retired but previously held the role of Chief Executive of NHS Lothian from May 2012 until August 2020.

2. I hold a B.A. (Honours) degree in History from University of Stirling (1983); a Diploma in Health Services Management from the Institute of Health Services Management (1986); a Master of Business Administration (MBA) from University of Glasgow (1991); and a Master of Public Health (MPH) from University of Glasgow (1997).

3. I joined the National Health Service (NHS) as a graduate management trainee in 1983 and worked for the NHS for 37 years before retiring in August 2020. I spent all of my career in the NHS in Scotland working in Forth Valley, Greater Glasgow, Lanarkshire and Lothian Health Board areas. I was the Chief Executive of three NHS trusts in Glasgow between 1994 and 2005. I was Chief Executive of NHS Lanarkshire from 2005 until 2012, and then I was Chief Executive of NHS Lothian from 2012 until 2020 until I retired.

4. I was off work due to serious illness and major surgery for two periods of time between July 2016 until January 2017, and April 2018 until September 2018. During both periods, my deputy chief executive Jim Crombie was the acting chief executive and also the acting accountable officer.

Role as Chief Executive of Lothian Health Board

5. The role of Chief Executive of NHS Lothian had a number of dimensions. The first dimension was to provide leadership to the Board and its staff. The second dimension was to be the accountable officer directly to the Scottish

Parliament. Accountable Officers are personally accountable to Scottish Parliament, through the Chief Executive/Director General for NHS Scotland. This is a personal responsibility for the propriety and regularity of the public finances for the health board and ensures that the resources of the health board are used economically, efficiently and effectively. The Accountable Officer role is set out in the Scottish Public Finance Manual and its annexes, and Section 14 of the Public Finance and Accountability (Scotland) Act 2000. The third dimension was to play a strong regional role within the east of Scotland. From 2017, I was appointed by the Scottish Government as Implementation Lead for the South East of Scotland Region for the implementation of the Scottish Government's health and social care delivery plan within the three Health Board areas of Borders, Fife, and Lothian. There was also a fourth dimension, which was a national role. Most of the chief executives of health boards also undertook a leadership role on a number of national initiatives. Most recently, I was a member of the National Planning Board, and I chaired for a number of years the Reshaping Care for Older People Programme Board, which was responsible for redeveloping services for older people in Scotland.

6. The chief executive role principally involved developing the Board's strategic aims, strategic vision, corporate objectives, the organisation's values and being responsible for delivering those, and specifically overseeing and agreeing the Board's annual operating plan with the Scottish Government, which included the key objectives and milestones that we were required to meet. The role would also involve liaising with the Chief Executive / Director General for NHS Scotland, Scottish Government's Chief Operating Officer and all of the directors within the Scottish Government's Health Directorates.

7. In relation to the Royal Hospital for Children and Young People / Department of Clinical Neurosciences (RHCYP/ DCN) project, my role was to make sure that the project was appropriately resourced, that it had appropriate governance and reporting arrangements, that it had good leadership, which included executive leadership, senior responsible officer, project owner, resourcing, project team, and clear escalation arrangements, both within the Board and to

the Scottish Government and with the Scottish Futures Trust. Also, as Chief Executive I was the line manager for the executive directors. Two of my most senior and experienced executive leads worked on this project during my 8 years in Lothian - Susan Goldsmith as Director of Finance, who was also the Senior Responsible Officer (SRO) for the project from 2012 to 2015; and Jim Crombie, my Deputy Chief Executive, who was SRO from 2015 until 2020. As their line manager, I was setting their personal objectives and making sure that this project was properly reflected in their personal annual performance plans for appraisal and review.

8. I reorganised the executive team after I was appointed to the role of Chief Executive for NHS Lothian in 2012. There was a perception that the executive directors of the health board were too remote from the management of the acute hospitals division and didn't have sufficient knowledge of the day-to-day management issues to intervene effectively. Within a few months of my arrival, I decided to merge the management team for acute hospitals with the Board's corporate management team to create a greater sense of cohesion and team working between the board's executive directors and the senior staff in the acute hospitals. As part of this change, I removed the role of Chief Operating Officer for the acute hospitals division and divided the role between my Medical Director and Nurse Director who took on responsibilities for scheduled acute care and unscheduled acute care respectively. As a result, Susan Goldsmith was appointed SRO for the Project in 2012 and she reported directly to me in that role, but also as the executive Director of Finance and the executive director who was responsible for our overall capital programme across the entirety of our capital investment projects.

9. Susan's role was principally around contracts and finance, therefore it was appropriate once financial close had been achieved on the project in 2015, for Jim Crombie to become the SRO which he held right through to my retirement in 2020. This is because the SRO role would become more focused on a process around clinical engagement, operational engagement, and eventually the commissioning of the project. Both Jim Crombie and Susan Goldsmith reported directly to me, and after Susan stepped down as SRO, she remained

heavily involved in the project working alongside Jim to provide support and expertise and to allow us to continue to benefit from her deep knowledge of the project and its history. Although Jim was the SRO from 2015, Susan remained responsible for contracts and financial engagement, which was particularly appropriate when we were in dispute with Integrated Health Services Lothian Limited (IHSL) (Project Co under the Project Agreement). Our Director of Capital Planning and Projects, Iain Graham, who was heavily involved in the Project from a commercial aspect, reported directly to Susan.

10. In relation to the governance and leadership arrangements on the project, I have been asked by the Inquiry what steps I took to ensure that I was meeting the requirements of the project. The steps were fairly conventional. As Chief Executive in all of the organisations I previously worked in, I was responsible for delivering very significant capital investment programmes. We invested close to £700 million in the time that I was managing NHS Lothian, and simultaneously with this project, two other major projects, the Royal Edinburgh Hospital Phase 1, which involved capital investment of circa £60 or £70 million, and the East Lothian Community Hospital, which was a £70 million project. All of those projects required to have governance arrangements as required by the Scottish Government and detailed in Scottish Capital Investment Manual (SCIM) and as set out in NHS Lothian's standing Financial Instructions and scheme of delegation.

11. For a project of the size of RHCYP/DCN, it was really important that we were clear about governance arrangements for the board of NHS Lothian and its committee structure. For this particular project this included the delegation of oversight authority to the Finance and Resources Committee, the creation of the Project Board, the creation of the project team, and the appointment of external technical, legal and financial advisors. This project architecture was already in place when I was appointed to NHS Lothian in 2012 and I considered it to be appropriate.

12. I have been asked to detail my support structure as Chief Executive. Within NHS Lothian the Chairman and the Chief Executive's office had two

administrative staff who supported us, and we had a more senior administrative support on top of that, who fulfilled a head of office function for the Chairman and the Chief Executive. Beyond that, my team was essentially executive directors. These were the Finance Director, Medical Director, Nurse Director, Public Health Director, HR Director, Planning Director, Primary Care Director and the Chief Officer of the acute hospitals division and subsequently, from 2017, my Deputy Chief Executive. I also had the Directors of each of the four Integration Joint Boards / Health and Social Care Partnerships from Edinburgh, East Lothian, Midlothian, and West Lothian, who reported jointly to me as Chief Executive of NHS Lothian, but also to the Chief Executives of the four councils for which they were established.

13. I have been asked by the Inquiry the extent of my involvement during the various stages of the RHCYP/DCN project. My role was pretty consistent up until 1 July 2019. Up until that date, I was not heavily involved in the detail of the project. My responsibility, as described above, was to make sure that it was appropriately resourced and supported and led, but I was not directly involved in any of the detailed negotiations or discussions with IHSL or external parties such as the Scottish Futures Trust other than as one step removed through briefings from and discussions with Susan Goldsmith and Jim Crombie. My role was principally either in a governance context as participating in the Finance and Resources Committee and in the Board itself, and through directly line managing, appraising and supporting Susan Goldsmith and Jim Crombie.

14. The NHS Lothian Board delegated governance oversight of the Project to the Finance and Resources Committee. The Finance and Resources Committee reported formally to the NHS Lothian Board and any material issues, whether for decision or for consideration and information, were frequently reported formally to the full NHS Lothian Board by the Chair of the Finance and Resources Committee (a non-executive member of the board) and/or by the Director of Finance and SRO. As a general rule, all Project issues would be taken to the Finance and Resources Committee (as per the delegated authority) unless there were material issues that impacted the delivery of the

Project, its timescales and its cost which required the full NHS Lothian Board to be informed and where appropriate directly involved in scrutiny and decision making. This happened frequently during the lifetime of the project.

15. As my office was next door to the offices of both Jim Crombie and Susan Goldsmith, we would see each other on a daily basis, and I was frequently and fully briefed by them throughout the life of the project on all of the major issues that arose. There was informal opportunity for me to be briefed as issues were emerging and there were also formal opportunities through our management team meetings, whether corporate management team meetings or through one-to-one meetings that I would have with my directors. Brief informal team meetings were held every morning, along with formal monthly meetings of the Corporate Management Team. I was kept informed of any substantial issues that they may have concerns about, or that they felt they were likely to require to escalate through the governance arrangements.

16. With a project this size and, bearing in mind this was one of a number of projects that we were developing at the same time, not every problem would be escalated, but there was a lot of concern internally within NHS Lothian and at Scottish Government level about delays and cost escalation with the RHCYP/DCN project. There were a lot of issues that arose which required to be addressed, and there was judgement applied by my executive directors about on what they believed should be escalated and if they were escalating something to the committee, they would generally talk to me about it in advance.

17. From 2 July 2019 and for the rest of that week, in particular, I was heavily involved in the detail and, in fact, by circumstances which were unfortunate, I was the only senior executive around for the whole period from 2 to 5 July that week. Susan Goldsmith was on annual leave and had just gone off on holiday. My deputy Jim Crombie had just gone off on sick leave and was off for a significant and extended period beyond which was unrelated to this project.

18. Also, at that time Tracey Gillies (Medical Director) was there for the first day but then had booked time off for a family graduation. Unfortunately, Alex

McMahon (Nursing Director) had a family bereavement and was on compassionate leave at the time. I would have been drawn into developments because of the seriousness of the issue at stake but due to the above circumstances, I had to take a more hands-on role than I would normally have been required to because my senior team were largely depleted. I had plenty of people to support me, but those particular key players were not around for the whole of that week.

Ventilation Assurance

19. I have been shown the following document by the Inquiry, (**A35270542 – Letter from DG Health and Social Care and CE NHSSScotland to NHS CEs setting out a set of action about an ongoing incident (Cryptococcus infections in QEUH – 25 January 2019 – Bundle 4 – Page 8)** and asked for my reaction on receiving this letter. I was aware of the publicity surrounding the Glasgow project in the media, a lot of it was focusing on pigeons on the roof and pigeon's droppings in plant rooms. In fact, three of the four bullet points within the letter are about plant rooms and only the fourth one is about ventilation systems. I thought the letter referred to existing facilities and facilities in the process of construction. Health Facilities Scotland (HFS) (Gordon James) subsequent correspondence confirmed that to be the case. I remember it coming in, and then making sure that it was delegated through Susan or Jim, and through the Project Board and project team. Jim was the SRO at this point in January 2019 and it would be looked at in detail by the executive directors and by the project team and a response would be drafted.

20. Although delegated to Jim, I believe it was Iain Graham, Director of Capital Planning and Projects, who would be likely to pull together the response, and he reported directly to Susan Goldsmith. It probably should be worth stating that in the NHS, matrix management is as important as direct line management, and it is common that someone might report to one director but be working also in support of other directors. Iain Graham had a series of dotted lines as well as straight lines, so the straight line was to Susan, but there was also a dotted line to a number of others, including Jim. The response

to the Scottish Government by all Health Boards would have been co-ordinated by Gordon James at HFS.

21. NHS Lothian responded to Gordon James' follow up letter **(A41293071 – Three letters relating to assurances regarding the delivery of the RHSC and DCN project, dated 01 April 2019, 12 February 2019 and 13 March 2019 – Bundle 4 – Page 228, Page 244 and Page 246)** which was signed by Iain Graham but would have been drafted and reviewed by the directors who formed part of the Project Team. The letter was based on the confirmation NHS Lothian received from IHSL that the hospital had been built according to standards and in accordance with the Project Agreement.

22. Had the letter been inadequate or incomplete in some way, or if any of the senior staff involved had concerns about our ability to respond with the appropriate level of assurance, I would have anticipated that would have been raised with me and it was not. It was a fairly straightforward response and had I been concerned about the response, I would have raised my concern, because I did look at it and read it. I believe that the letter drafted by Iain did provide assurance on the four areas that the Scottish Government had set out.

23. I think the letter was fairly explanatory and tried to describe that this was a different project from the Glasgow project. It was not a capital funded project, and we did not design the building, nor did we have a relationship directly with the builder of the hospital. This was a Non-Profit Distribution (NPD) style design and build so we were one step, if not two steps, removed from the project.

24. NHS Lothian were placing reliance on IHSL and the Independent Tester (Arcadis) to ensure compliance. This is inherent in the NPD model of procurement. The Health Board had no contractual obligation or indeed right to monitor or inspect the works during the construction phase to ensure compliance. The Independent tester, Arcadis, had a role in the construction phase, including attending monthly site progress meetings, undertaking regular

inspections of the Works, identifying any work that was non-compliant and reporting on completion status of the project.

25. As noted above, I took reassurance from Mr Weir's confirmation of compliance with SHTM 03-01 in early 2019. On 31.1.19, Wallace Weir of IHSL wrote to Brian Currie (**A43103366 – IHS Lothian letter re compliance with SHTM dated 31 January 2019 – Bundle 13, Volume 7 – Page 425)** with (inter alia) confirmation that *"All ventilation systems have been designed, installed and commissioned in line with SHTM 03-01 as required, systems are maintained in such a manner which allows handover at actual completion to meet SHTM 03/01 standards"*.

26. On 12.2.19, Mr Currie wrote to Mr Weir (**A40988842 – Letter from NHSL to IHSL re assurance – 12 February 2019 – Bundle 13, Volume 7 – Page 427)** seeking written assurance on various matters, including that engineering systems had been designed and were being installed and commissioned to meet current guidance; that the engineering systems had been commissioned, validated and set to work to ensure safety, quality and compliance; and that the systems to be handed over at actual completion met the specified requirements and are safe and effective.

27. On 13.3.19, Mr Weir wrote to Mr Currie in slightly different terms to his letter of 31.1.19, (Mr Weir's letter of 13.3.19 is enclosed with Mr Graham's letter to Mr James of 1.4.19) **(A41293071 – Three letters relating to assurances regarding the delivery of the RHSC and DCN project, dated 01 April 2019, 12 February 2019 and 13 March 2019 – Bundle 4 – Page 228, Page 244 and Page 246)** confirming inter alia that the engineering systems had been designed/installed/commissioned/validated in accordance with the Project Agreement. At that time, the Project Agreement had been amended by SA1.

28. Mr Weir's letters were an appropriate description of the fact that, as advised by NHS Lothian's advisers, we had a Project Agreement that covered the issues and that we had Board Construction Requirements that were absolutely clear about the need to adhere to SHTM 03-01, subject to any agreed derogations. In hindsight, it may have been helpful to specifically mention the ventilation

derogations from SHTM 03-01 that had been agreed as part of the Supplemental Agreement (SA1) which could have prompted further scrutiny. and revealed the problem that later emerged in 2019. That said, NHS Lothian had already taken and relied on technical advice from Mott Macdonald Ltd (MML) in relation to the SA1 technical schedule, so the scrutiny of any agreed derogations had in effect already happened and we were receiving assurance that the ventilation had been designed/installed/commissioned/validated in line with what we thought we had agreed to. It is of course key to note that, at the time, NHS Lothian did not consider that it had agreed to derogations to 4ACH to critical care.

29. Even if the letters had listed the derogations, the overall outcome would have remained the same because NHS Lothian were not aware that the derogations to 4ACH for single rooms and multi-bedded rooms as set out in SA1 had also been applied by IHSL to single rooms and multi-bed rooms in critical care. The fact remained that IHSL had designed and installed a ventilation system by 2016/17 that was incapable of providing 10 air changes an hour to most of the rooms in critical care, and this failure to comply had been compounded by human error in including multi-bedded rooms in critical care in the derogation to 4ACH.

Period between January 2019 and July 2019

Settlement Agreement 1 (SA1)

30. I have been asked by the Inquiry if I had any involvement in the signing off on the SA1. I did, both in my capacity as a member of the Finance and Resources Committee and a member of the full NHS Lothian Board, but also as the line manager of Susan Goldsmith and Jim Crombie who discussed the issues that were being proposed to our governance structures with me in advance.

31. Before SA1 was agreed, NHS Lothian and IHSL were in a long-standing dispute regarding air pressure in four bedded bays together with other outstanding construction issues. In order to avoid court action and progress the completion of the construction of the hospital, both parties agreed to enter into

SA1. At this time NHS Lothian were told that IHSL were close to liquidation as there was no cash flow to meet the cost of servicing the debt arrangements under the NPD structure. SA1 included agreement on the outstanding works along with the commencement of capital payments to inject cash flow to IHSL.

32. I was aware of the severity of the concerns around the potential failure of the project and the potentially catastrophic level of further unlimited delay and uncertainty for the project's completion if IHSL collapsed. The full board of NHS Lothian and Finance & Resources Committee received reports updating on the progress with negotiations and seeking approval to enter into SA1. I was not part of the discussions on the technical matters of SA1 as this was being advanced by the Project Team along with advice from our technical advisers, MML. As discussed below, I was aware that the SA1 involved derogations from national standards and guidance but I was not aware that included derogations to rooms in critical care.

33. With regards updates to Scottish Government the interaction with them was principally through Susan Goldsmith or with Jim Crombie but mainly with Susan, who was leading on the contractual issues. There was very direct engagement between Susan and the Scottish Government, especially Alan Morrison and the wider capital team in the Scottish Government, and with the Scottish Futures Trust (SFT). Susan briefed me on her interactions with SFT and Scottish Government, so I was very confident that the engagement with the Scottish Government and with SFT was working appropriately. We were responsible for the project, the contract was with us, and our accountability was to the Scottish Government through the Board. I would expect SFT to raise issues either with us or with the Board if they felt they weren't being properly addressed.

34. I was aware that Jim Crombie had raised a number of issues with IHSL, and they responded, and that there was a lot of what I would describe as "noise in the system". There was concern that the project might slip. We had agreed to commission the hospital at the same time as the outstanding works were being completed, which I think was probably a mistake in retrospect, but we were

very keen to try and get the hospital open before the winter. Had we not agreed to SA1, there was a real risk of IHSL becoming insolvent and collapsing, in which case the project would have come to a halt. SA1 was not ideal but it was the best option available to us to keep the project alive and deliver certainty about project completion.

35. I had never been involved with an NPD project, and no one else in Scotland had in relation to a health building. Whilst I was Chief Executive of NHS Lanarkshire, I was responsible for the operational management of two large PPP hospitals at Wishaw General and Hairmyres Hospital. Therefore, I had an understanding on how the Project Agreement should work once it got to the operational phase. NHS Lothian's NPD project was the first of its type, and the last, but for such significant ongoing works to be done at the same time as the hospital was being commissioned, meant by its very nature that the validation of systems was going to be done at the last minute. In hindsight, I think that was a mistake but, I would caveat that mistake by saying that even if we had done that more conventionally, e.g. staged it so that the ongoing works were done and then commissioning thereafter, we still would have found that the ventilation was inadequate. It's just that we would have found out about the ventilation issue with more time before the planned opening. As it was, we found out a week before the hospital was planned to open.

36. I have been asked by the Inquiry if I had been advised of the ventilation issues before Jim Crombie had issued the letter to IHSL (Jim Crombie to Wallace Weir of 7.6.19 **(A41293059 – Letter from Jim Crombie to Wallace Weir on concerns about the progress of the Post Completion Works, Outstanding Work and Snagging Matters dated 7 June 2019 - Bundle 13, Volume 4 – Page 6).** I really cannot recall the detail but, I would imagine that I would have been aware through informal briefing. SA1 had around 80 items of issues on it; that there were numerous issues that were still being worked through and resolved was not a surprise to me. At that point, there was a confidence that we would be able to resolve the issues, and IHSL's response to Jim Crombie's letter was fairly reassuring.

Derogations in Settlement Agreement 1 ("SA1")

37. Up until 1 July 2019, NHS Lothian believed the Project Agreement and the published guidance were one and the same thing in relation to the application of SHTM 03-01 to critical care. Indeed, there was an independent tester (Arcadis) who had signed off on the commissioning of the ventilation systems and provided a Certificate of Practical Completion to NHS Lothian entering SA1. I think it would have been reasonable for the independent tester to at least query the ventilation arrangements for critical care as being materially non-compliant with published guidance during that process. He did not.

38. I understand there was a technical schedule to SA1, which set out all of the issues that had arisen during the project and the agreed resolutions, including in relation to derogations for ventilation, but I was not aware of the detail of the technical schedule at the time it was drafted.

39. By the time SA1 had been agreed; it was a reflection of what IHSL had already designed and installed; and NHS Lothian thought it was a reflection of what they thought had agreed to IHSL designing and installing. During the construction period, there had been three issues in relation to ventilation: (i) pressure regimes for multi-bed wards; (ii) a derogation from 6ACH to 4ACH for single bedrooms; and (iii) derogations for Lochranza which was the haemato-oncology ward. I was aware of the first two issues during construction but I cannot recall whether I was aware of the issues re Lochranza.

Pressure Regime

40. I was aware that there had been derogations agreed in SA1 in relation to the pressure regimes for multi-bed wards. Air change rates were not discussed as far as I'm aware. The clinicians' major concern was to allow patients with the same infectious diseases to be cohorted appropriately. The reason for having balanced or negative pressure in a multi-bed room is to prevent airborne pathogens leaking out from that room in to the corridor where it can reach other vulnerable patients. IHSL and Multiplex disagreed and this led to months of protracted correspondence and a threatened court action in relation to

whether NHS Lothian or IHSL had the final say on what should be delivered. This goes to the heart of the dispute and problem with NPD, which was that NHS Lothian didn't design this hospital. There was a reference design but, in terms of the contract, IHSL were responsible for reviewing and delivering a design and build that was compliant with Guidance, subject to any proposed and agreed derogations from Guidance.

41. This dispute was ultimately resolved and was included in the SA1 technical schedule to reflect that 14 of the 20 multi-bedded rooms would have balanced pressure and, in addition, 4ACH. Unfortunately, what was not flagged or picked up by anyone at that time was that, in relation to the multi-bed rooms in critical care, this was in fact a deviation from SHTM 03-01 which required balanced pressure and 10 ACH.

<u>6ACH to 4ACH</u>

42. Even before we had signed off SA1, from around May 2018 onwards IHSL were desperate for us to agree a derogation from six air changes to four air changes. However, this derogation was never mentioned in the context of critical care, which would require a derogation from 10ACH. We now know that they had already installed a system that could not achieve 6ACH, let alone 10ACH, so of course they were desperate to get us to agree derogations and it was arguably not in their interest to specifically flag that they considered that included critical care.

43. I also understand from evidence heard at prior Hearings of the Public Inquiry that the M&E designers, TUV SUD, considered that it was only isolation cubicles in critical care that require to have 10ACH, and that all other rooms would have a starting point of 6ACH, so in their mind what they delivered in critical care was in fact compliant with Guidance.

44. From what I know now, the ventilation issue had already been baked in to the building as IHSL had designed and built the hospital to 4ACH. IHSL had only ever intended the isolation rooms in critical care to have 10ACH. This non-

compliance was not flagged by IHSL or ever proposed as a derogation from Guidance and was missed by NHS Lothian and MML.

45. I understand that, in terms of NHS Lothian's Clinical Output Specification, Multiplex were informed that all the rooms within clinical care had to be interchangeable with each other and compliant with Guidance. All 24 beds had to be able to be at the level of critical care. There were plenty of opportunities for IHSL, Mulitplex, TUV SUD and MML to raise this as an issue and for the independent tester, Arcadis, to flag that the air changes are not what is required in terms of the Guidance. The independent tester seems to have accepted that the agreed position was for 4 ACH. I honestly don't know how there can be five or six parties who could and should have identified this much earlier in the process and didn't.

Lochranza

46. I cannot recall being involved in any discussion before 1 July 2019 about derogations affecting Lochranza. I only became aware of this issue subsequently as part of the second Supplementary Agreement (SA2) which documented the remedial and improvement works. I assume I was not aware of the Lochranza derogations because they were not considered to be an area of dispute and had been agreed by our Project Team and the senior clinicians in that unit. I believe had there been a problem, it would have been escalated to me. It wasn't, but I was aware of the derogations more generally, and I was aware that Glasgow had also agreed derogations as part of their building.

Commissioning and Validation

47. I was not aware of specific concerns being raised by IPC in particular about the commissioning data available but was aware of a more general acceptance by the project team and my senior directors that we required to bring in another independent tester, IOM, as part of the validation process to give us final assurance that the move could go ahead as planned.

48. We were anticipating that the IOM testing would reveal adequate responses, and it did for the vast majority of the hospital. It was this specific issue of the Critical Care unit that was raised. I think our understanding at this time was our Project Agreement had been clear, our construction requirements had been clear. IHSL had fairly recently written directly to us to confirm that they had implemented SHTM 03-01 (Wallace Weir's letter of 31.1.19) **(A43103366 – IHS Lothian letter re compliance with SHTM dated 31 January 2019 – Bundle 13, Volume 7 – Page 425)**. My senior team involved directly in the project were all clear that critical care was a 24-bedded ward as detailed in the Clinical Output Specification, it wasn't just four isolation rooms. As far as we understood it IHSL had never proposed a derogation from 10ACH for single or multi-bed rooms in critical care.

01 July 2019 - Discovery of Critical Care issue

49. I have been asked by the Inquiry of my recollection of an email sent by Tracey Gillies **(A41020535 - Email thread regarding water quality and ventilation issues - 1 July 2019 – Bundle 13, Volume 4 – Page 10)** regarding the testing conducted on the water quality and ventilation. I was aware that IOM had been commissioned to undertake pre-occupation testing of the new hospital as part of validation but I was not part of the appointment process. On the Friday evening, 28 June 2019, Susan Goldsmith had also made me aware that there were a number of issues that the IOM testing had flagged that were causing concern.

50. There were particular concerns about whether the theatres were delivering the right results. Now, at that time, I was aware that IOM had not yet fully tested every area, and so there was some uncertainty about whether the tests were accurate, whether they were fully comprehensive or whether they were partial and, of course, whether the readings that were being shown could be remedied if there was a problem. I believe that Susan was heading off on holiday the following week so had phoned me on Friday evening to brief me on a few issues, which included the IOM findings especially in relation to theatres.

51. The email on Monday followed what Susan had briefed me on the Friday evening. I knew that Tracey Gillies and Alex McMahon were going to be meeting with IOM and the project team that day and I would be briefed later in the day as to the outcome.

52. At that point, I would still have been anticipating that we could resolve these issues although it was going to be very close to the wire. That evening (Mon 01 July 2019) I received a further email from Tracey Gillies **(A41263213 - Email thread regarding RHCYP critical care ventilation issues - 1 July 2019 – Bundle 13, Volume 4 – Page 16)**, where she highlighted her concerns following the further testing of the ventilation by IOM. I don't recall opening that email on the Monday as I had probably stopped looking at emails by this time. I would have picked it up first thing on Tuesday morning and I phoned Tracey immediately, who appraised me of the situation. Following this conversation, I then arranged an emergency meeting for that morning.

53. I cannot remember whether I was aware from a conversation with Tracey Gillies on Tuesday 2 July or from Susan Goldsmith on the Friday but I was aware that even if all the theatres had not been able to pass their IOM checking, we were hoping to have at least two theatres for DCN and two theatres for the RHCYP ready and commissionable for the week ahead, with an expectation that the others would follow on track for any work that required to be done. I was very concerned because I had been fully anticipating that we would resolve the issues, however Tracey's message was pretty clear that this was unlikely to be resolved quickly.

54. I have been asked by the Inquiry what my reaction would be if individuals within the Health Board were aware of the Critical Care issue before I was informed. I would be very surprised and disappointed if someone had known about this and had been sitting on it. I should have been made aware as soon as the issue became apparent, and I believe that is what happened. I was made aware of the issue on Monday evening (01 July 2019) by Tracey Gillies and I escalated that to the Scottish Government on the Tuesday morning (02 July 2019).

55. I did become aware in the days that followed the Critical Care issues being brought to my attention that the Project Team had first been alerted on 24 June 2019 by IOM that there may be issues and that they were trying to understand the results, whether or not they were accurate and comprehensive. I also understand that the main focus that week had been on theatres. I think that was a reasonable approach.

56. I would also comment that it would not have made any material difference. If Brian Currie had escalated the IOM findings to Susan Goldsmith and Alex McMahon about Critical Care on 24 June and they had escalated it to me, then I would have known that there was a potential issue a week earlier. My understanding is that at that time they were unclear as to the severity or otherwise of the issue, which is why they did not escalate it, and were undertaking investigations to clarify the position. So escalating what was at the time a potential issue would not have made much difference and would not have changed the materiality of it. We would have been exactly where we were on 1 July, just I would have known there may be a potential issue a week earlier. The Cabinet Secretary in her statement to Parliament acknowledged that it was NHS Lothian's validation process and appointment of IOM that found the problem, no one else found the problem, but her concern was that it was found so close to the opening. The materiality of another week in the knowledge of a potential issue would have made no difference because we did not have confirmation as to the severity of the issue until 1 July.

57. I agree with the Cabinet Secretary that it was very late in the day to be finding this out. This was because we had agreed to commission the building at the same time as IHSL were completing the outstanding works as agreed in SA1. This resulted in the final validation of the ventilation system being conducted close to the opening because NHS Lothian had to wait until all the outstanding works were complete and the hospital was clean before the validation checks could begin. It was only through the validation process and instruction of IOM the issue was identified and escalated, but the issue was baked in as early as 2016/2017 and we really should have known about the proposed derogations for critical care then, but the issue was never flagged.

2 July 2019

Emergency Meeting

58. Within an hour or two of having seen Tracey's email on 2 July 2019 (email dated 1 July 2019) **(A41263213 - Email thread regarding RHCYP critical care ventilation issues - 1 July 2019 – Bundle 13, Volume 4 – Page 16)**, I convened and chaired an emergency meeting with the team. There were a number of people present at (or who had dialled in to) the emergency meeting. These included Susan Goldsmith, Iain Graham, Brian Currie, Dr Donald Inverarity, Tracey Gillies, Eddie Doyle (Associate Medical Director), Jackie Campbell (Chief Officer of Acute Hospitals), and Fiona Mitchell (Director for Women's and Children's Services).

59. It was important that I was appraised of just how serious this was, what could be done, whether the situation was retrievable and what options were available to us. It became very clear from the emergency meeting that it was very likely we would need to postpone the move to the new hospital.

60. I wanted some clarity on whether what the IOM testing was showing us was complete and accurate and if there were permanent or interim solutions available. This included questions about whether the existing plant and the existing ducting could be powerful enough to deliver 10ACH or if additional air handling units were required.

61. The discussion was along the lines of here we have a brand-new hospital and we were expecting 10ACH; we need 10ACH; and we wouldn't have agreed a derogation from 10ACH to 4ACH, knowingly or wittingly, and therefore we would not be able to move in with it being below 10ACH, unless we were confident that we could have a plan that would get us to 10ACH. We discussed things like whether there was an interim fix achievable; whether an interim fix could be done safely once we'd already moved in; how long a permanent fix would take to resolve; and if we were going to have to delay, how long it would take.

62. Discussions included issues such as a potential change of ducting; whether roof tiles would need to be taken down; what noise disruption would there be; what about dust and debris; and could it be done without a loss of operational capacity. It was our view that if the ducting was going to require changing, then it would have to be done in each of the rooms, and we would not be able to use those rooms while the work was being done. As a minimum, rooms were going to have to be closed off to allow the work to be done, and that would result in a loss of operational capacity. We could not afford to lose capacity as the RHSC was part of a national network of critical care in Scotland, in conjunction with Glasgow in particular.

63. One of the outcomes of the meeting was that those in attendance would engage with their appropriate counterparts to get answers to the questions discussed. For example, those within Infection Control would speak to HFS and HPS and those in the project team would speak to Multiplex and IHSL. We would reconvene later that afternoon and see where we had got to.

64. It became clear at that meeting that we needed to make a decision by the following day, which gave us a maximum of two working days to reach a decision because the move, albeit of administrative staff and associated equipment only, was going to start on Friday 5 July and the emergency department was due to be commissioned and opened by the following Tuesday, 9 July. My view was if this is going to be stopped, it needs to be stopped by the following day. We recognised that we might be having to make a decision with incomplete information, but we couldn't not make a decision.

65. My recollection was there was an interim conclusion that it was highly likely that we would have to postpone some or all of the move. We had not yet reached that decision but it was clear that this was not something that we were going to be happily resolving by the end of the day, hence my escalation of the issue.

Escalation to Scottish Government

66. After the meeting I immediately phoned Malcolm Wright's office (Chief Executive NHS Scotland/Director General for Health and Social Care) and asked for an appointment to speak to Malcolm urgently that day. It was arranged that we would speak on the phone at 1pm. I briefed my chairman, Brian Houston, and he sat in with me on the telephone call with Malcolm Wright and John Connaghan.

67. The conversation with Malcolm Wright and John Connaghan was very constructive, professional, and detailed. They listened to my briefing, which described the situation, and that we were pretty clear now that the ventilation system was inadequate and could not deliver the 10 ACH without further work and we were considering our options.

68. I talked through all of the issues that we were addressing and questions we were trying to get answered. During the conversation I recall John Connaghan asking about moving in and then decanting critical care. I explained this would be difficult to achieve due to the absence of appropriate decant space adjacent to the new hospital and that a temporary modular unit decant solution would also be an expensive and lengthy process, based on my knowledge of the length it time it had taken to plan, receive the necessary consent, purchase and install a recent modular solution for additional space for the Emergency department at the Royal Infirmary of Edinburgh.

69. I was aware that there was unlikely to be a quick fix, but I also remember John Connaghan asking a question in relation to the potential for a partial move of services not reliant on critical care recognising that we were planning to move the DCN from the Western General, which was not reliant upon Critical Care at RHSC.

70. We were also looking to move the Child and Adolescent Mental Health Services (CAMHS) from the Royal Edinburgh Hospital, which is not reliant on Critical Care, and we had a whole raft of paediatric services from RHSC, such as community health services, outpatient services, ambulatory care services,

that could move in because they were not reliant on in-patient beds or theatres or an emergency department. I thought that discussion was practical, pragmatic, constructive, and we agreed that we would reconvene by phone later that day, which happened to be in the evening when I had more information.

71. I have been asked by the Inquiry if there was any indication given at that time from either John Connaghan or Malcolm Wright that the ultimate decision regarding how matters were going to proceed would be taken by the Scottish Government or was the indication that it would be the Lothian Health Board who decided what was going to happen. I don't think that was explicitly said to me at that time. I think it was very clear the following day though, on 3 July 2019, when we had a further meeting with John Connaghan **(A35827798 - Draft meeting note (1400hrs) on Commissioning and Ventilation issues at RHCYP/DCN - 3 July 2019 – Bundle 7, Volume 1 (of 3) – Page 57)** .

72. Later on in the day of 2 July, I asked our legal adviser to clarify the detail in SA1 of the rooms that had been included in the derogation to 4ACH and learnt that arguably the rooms in critical care had been included in the SA1 technical schedule. I called a meeting of all key internal colleagues and our external legal adviser and technical adviser in the subsequent few days to begin to understand how the critical care rooms had arguably been included in the derogations. It was clear that multi-bed rooms had been included because the drawings referred to included 4 bedrooms located in critical care. As above, we had wanted multi-bed rooms to have balanced pressure but were unaware that was a derogation from Guidance in relation to multi-bedrooms in critical care. It was not clear that the derogation for single bedrooms from 6ACH to 4ACH expressly applied to single rooms in critical care. However, given the error in the Environmental Matrix it was arguable that it did.

73. The priority work agreed with Scottish Government was to get the ventilation issue resolved and get the new hospital opened as quickly as possible, rather than get too distracted by investigation as to how it had happened. The KPMG review of governance arrangements and the Grant Thornton Report eventually overtook the investigative process.

Communications

74. I have been asked about a briefing note sent by email by Judith MacKay, NHS Lothian's Communication Director **(A35827755 – Email from Judith McKay (NHS Lothian) to Chief Executive et al attaching a Comms Handling Plan - 3 July 2019 - Bundle 7, Volume 1 (of 3) – Page 70).** The briefing (**Page 71**) summarised the internal discussion held during the course of day on Tuesday 2 July 2019. It was a snapshot of what was known as that time and it evolved through the course of the next few days where a clearer understanding of the issues developed.

75. Judith Mackay had also drafted a briefing (SBAR) regarding the emerging Critical care issue which included potential options. This was emailed to myself, Malcolm Wright and Alan Morrison. It was forwarded on to the Cabinet Secretary and John Connaghan by Alan Morrison **(A35184277 - Email from Alan Morrison to Rowena Roche et al attaching a RHCYP brief – 25 July 2019 – Bundle 7, Volume 1 (of 3) – Page 36)**.

76. This was the beginnings of agreeing communications strategies about what was likely to happen in the next day or two between Judith and her comms team. The way that Scottish Government works is that they have departments that deal directly with functions of boards, so not everything from government comes through the chief executive. The finance directorates would be speaking directly to the finance director, the performance people would be speaking directly to the acute hospitals people, etc. I would have asked Judith to make sure that she was pulling together communications lines and agreeing them with the communication team at Scottish Government, and I know that Judith would have been in very regular dialogue with them as this was emerging.

3 July 2019

HFS/HPS meeting

77. I dialled into a meeting on the morning of 3 July 2019, with Alan Morrison, Eddie McLaughlan, and Ian Storrar from HFS, Lisa Ritchie from HPS and Iain Graham and Jackie Campbell from Lothian Health Board. The minutes of that meeting are within **(A35827794 - Email forwarded by Iain Graham – Bundle 13, Volume 4 – Page 1326)**. It was a helpful meeting in that it was intensely pragmatic and practical. I remember outlining our current understanding of the situation, the fact that we were uncertain about how long it would take to fix this problem, the impact that it was likely to have in terms of noise and air pollution, and how much of the facility we would have to close down in order to do any remedial work. The focus was on RHCYP rather than the DCN.

78. The feedback from HFS and HPS was to consider whether we had a contingency plan for what would happen if we moved in but could not fix it adequately, could not decant it adequately and would the lose operational capacity. I told them we did not have a contingency plan and were unlikely to have one developed within the next six hours. We continued to discuss the situation and all came to the conclusion that the move was too risky. We did discuss the condition of the RHSC at Sciennes and, had there been a view that Sciennes was unsafe or that DCN was unsafe, then that would have been a stronger driver to move. However, the clinical view that was clearly expressed to me by Eddie Doyle, Associate Medical Director, supported by Tracey Gillies, Medical Director, was that remaining at Sciennes was a low-risk option **(A41292981 – Sec21_B_00001857 – Bundle 13, Volume 4 – Page 20)**. The current site was a safe environment, a known environment, and we would be moving from a safe and known environment into an unknown environment in terms of not knowing how the fix could be achieved.

79. I was aware that the site at Sciennes had no mechanical ventilation, but safety is a very multi-dimensional concept: air changes is one issue, air pressure another, but there are others such as appropriately trained staff and having the right number of staff, clinical supervision and procedures.

80. Staff and patient safety is a much more rounded multi-dimensional concept than just ventilation. The ventilation is one component, but the view was that Sciennes was safe and therefore there wasn't an immediate patient or staff safety pressure that said we must move.

81. Separately, at the DCN we had more concerns because of the Pseudomonas risk but, again, the view was that Pseudomonas is something that occurs in old hospital buildings but was being managed with appropriate Infection Control measures that we were implementing. Our principal priority in all of this was how do we ensure the safety of our patients and staff? The conclusion was it was too uncertain to move the critical care unit, there was no contingency plan, there were too many unknowns.

82. We discussed what a phased move in could look like. It would have taken subsequent engagement with clinicians to plan it, because we'd never thought about moving in on a phased basis, but we felt that it was at least feasible that we could move some parts of paediatric services. These could be big volume services like outpatients, community child health services, ambulatory care services, possibly even some forms of day surgery could potentially have gone on. We also could have moved in elements of CAMHS and the Inpatient Unit eventually and our view was we could, and should, proceed with moving DCN in.

83. There were issues about clinical adjacencies for DCN, about fire evacuation, about catering. There were issues about anaesthetic rotas because DCN was part of the adult critical care service but, paediatric theatres also had anaesthetic junior medical staffing, and so there were issues that if the totality of DCN and paediatrics were not moving in, we had to consider whether that gave us enough anaesthetic cover across all of the rotas, from the junior to the most senior. Because we would not be moving everything in we would have had to dislocate Critical Care cover from the Western General to move into the Royal Infirmary.

84. At the meeting with HFS (Eddie McLaughlin and Ian Storrar) and HPS (Lisa Ritchie) there was an agreement that Critical Care could not move in, or should

not move in, however it was not HFS and HPS call to make. They would be giving me their advice, but we were managing the service. There was definitely agreement that we should not proceed with Critical Care and therefore should not proceed with the other interdependent services although I don't think we discussed that with them as our discussion was principally around Critical Care and we came away from that meeting all on the same page. I have been asked by the Inquiry if the consensus of not moving was in relation to the Critical care unit alone or the entire hospital. At this point in time it was for the Critical Care unit alone. I think there was a feeling that the other ventilation issues could be remediable in time and would not have prevented the move. The issue with Critical Care was the clinical interdependencies meant that if the critical care move was delayed, then we would also have to delay the move for the Emergency Department, all paediatric in patient services and most theatre work. It is very much like the pieces of a jigsaw, once you've said Critical Care is not able to move, then all paediatric inpatient services, would have had to stay at the RHSC, unlike DCN, which was to be supported by adult critical care at the Royal Infirmary of Edinburgh

85. In summary, there were issues that still had to be resolved but our thinking was that we could have proceeded with a phased move if the Cabinet Secretary was agreeable to that. We would need to go away and start engaging with all of our clinicians to put together a phased plan, which would still have involved an element of delay to the planned opening. Had the Cabinet Secretary agreed with my recommendation that we come forward with a re-phased plan, we would have spent the next two or three weeks developing that plan, having those discussions, and deciding what we could move and when.

<u>Internal meeting</u>

86. At one o'clock on 3 July 2019 I reconvened my group and we had a meeting. At the start of the meeting, we did not have a firm view. It was clear in people's minds what the options were and the pros and cons of each of the options, but we were aware we needed to make a recommendation in terms of NHS

Lothian's preferred option to Scottish Government, to be discussed with the Scottish Government at a meeting scheduled for later on that day.

87. We identified four potential options as possible routes forward and the minutes of that meeting **(A41292981 – Sec21_B_00001857 – Bundle 13, Volume 4 – Page 17)** summarise how these options were reached. In summary, there were four options available:

- *"Continue with the planned move and attempt to deliver a permanent fix for the ventilation problem while the Critical Care Unit remained open.*
- *Continue with the planned move of all services and then decant Critical Care into a modular build unit to allow the optimum solution to be delivered in an empty environment.*
- *Defer moving into the new building altogether.*
- *Re-phase the timing of the move into the building to allow a phased occupation over the next few weeks and months."*

88. The fourth option was NHS Lothian's preferred option. As detailed earlier, my initial view was that NHS Lothian would be making the decision of which option we went with because we were running the project but by the meeting at one o'clock on 3 July, I was articulating to my team that the Scottish Government would be making the decision. I can only assume that John Connaghan had said that to me when he phoned me on the evening of the 2 July, but I don't recall the exact conversation. I presume that he informed me that the Cabinet Secretary has been briefed and she wanted to make the decision and it was agreed to reconvene at a meeting with Scottish Government at 2pm on 3 July.

89. I was fairly pragmatic about this decision as Health Boards only exist as a vehicle for the government to run the Health Service. The government had a very low bar about ministerial intervention in the Health Service. Since the Scottish Government came to power in 2007, there had been a far more micromanaged approach to the Health Service from government than had previously existed under other regimes.

90. There was also a presumption against the centralisation of clinical services from multiple hospital sites to a single or fewer sites, such as centralising emergency departments on fewer sites. So even fairly low scale decisions that would previously have been made by Health Boards were now reserved for ministers to decide upon because of the presumption against centralisation. For the Scottish Government to want to micromanage and take control of a highly public problem would not have been a surprise to me.

Meeting with Scottish Government at 2pm

91. At two o'clock on 3 July a number of individuals left the meeting and John Connaghan and Suzanne Hart then joined us from Scottish Government. I believe Suzanne had a role in communications for Scottish Government. We were also joined by Alan Morrison who dialled in to the meeting. John was very clear at the start of the meeting that the Cabinet Secretary was going to make the decision on the way forward and would be briefed following this meeting. I was therefore being asked for my advice on what I thought the options were, what my appraisal of the options was, and what my advice would be about how to proceed. I recommended the fourth option detailed above, i.e. that we re-phase the timing of the move into the building to allow a phased occupation over the next few weeks and months.

92. During this meeting John Connaghan did ask whether there were any other issues that could emerge or was it just the Critical care unit that was the extent of the position. I believe Malcolm Wright had also posed that same question to me. At that time, I was confident that there were no other issues and that was my response to John Connaghan. It was the Critical Care issue that was causing the problem, and that there was nothing else of materiality that would stop the move, and that was our honest opinion. I have been asked by the Inquiry if I recall John Connaghan being told about the derogations implemented in the Lochranza Ward, which is where the Haematology and Oncology unit was located. I don't think we discussed that at all at this meeting.

93. Another issue raised by John Connaghan during the meeting was the development of a communications plan. At the end of that meeting, John asked me to set out my understanding of the issues in writing, the options we had considered, my appraisal of the options and my advice about the preferred options as we had discussed during the meeting. In other words, he was comfortable with the preferred option that I had described. I was anticipating that he would be briefing the Cabinet Secretary that he had met with NHS Lothian and that our proposal is reasonable. He didn't say he was going to do that, and he wouldn't because, at the end of the day, his advice to ministers is confidential, but he didn't suggest any opposition to it. I assumed because of that, that he was generally supportive of our position, but I also am long enough in the tooth to know that ministers don't always accept advice from colleagues or from civil servants, and he had made clear the Cabinet Secretary would make the decision and therefore that decision might not be in line with what we were recommending. That was a fully possible outcome.

94. I anticipated that he would be briefing the Cabinet Secretary, and that Judith Mackay would be working on the communications plan on that basis. At that time, my understanding and my expectation was that, although the Cabinet Secretary was making the decision, we were still responsible for the contract and the service therefore NHS Lothian would be leading on communicating both internally with our own staff and also externally. It was my belief that the Scottish Government would be supportive of this position and that was my expectation until the evening of the 3rd July, when the position changed.

95. Following the meeting with Scottish Government, as requested, I sent an email to Malcolm Wright and John Connaghan **(A41020529 – RHCYP_DCN Commissioning ventilation – Bundle 13, Volume 3 – Page 1141)**, which outlined the four options that NHS Lothian had considered and our preferred option of re-phasing the timing of the move into the building to allow a phased occupation over the next few weeks and months.

96. This was my assessment, having taken advice from the range of people, which included my chairman, HFS, HPS, my clinical colleagues, the senior colleagues within NHS Lothian and my discussions with John Connaghan. However, this never went to the Finance and Resources Committee or the NHS Lothian Board, because there was not enough time. This was my assessment as NHS Lothian's Chief Executive, in the time available.

97. I have been asked by the Inquiry if John Connaghan agreed that the actions and preferred option was authorised on behalf of Scottish Government. I don't think that was the case. I don't think he was in a position to agree or not with NHS Lothian's preferred option, because he had told us that the Cabinet Secretary would make the final decision. He will have been reserving his view for advising the Cabinet Secretary and advice to ministers is confidential.

98. If the Cabinet Secretary had agreed with our preferred option, NHS Lothian would have immediately put in place rapid engagement with the senior clinicians and managers of those services to ask if / when the services were able to move. Outpatient services and DCN would likely have taken priority and been one of the first to move. I have been asked by the Inquiry if the outpatient services and DCN would have moved on 9 July as planned. It would have been premature to have made that assumption. However, there was more of an expectation that DCN could and should move because it was largely ring-fenced and supported by adult critical care from the main adult critical care unit in the existing Royal Infirmary of Edinburgh.

<u>Communications</u>

99. At this time, we were also putting together a communications plan as we were anticipating having to go public the following morning with whatever the Cabinet Secretary would decide upon. I was liaising with Judith Mackay from our Communications team, who was desperately trying to pull communication lines together based on what was being discussed at the meeting. In retrospect, the lines were a bit ahead of themselves.

100. On the evening of 3 July, I was in touch with John Connaghan and Malcolm Wright, and I believe both had seen the communications plan Judith had pulled together by this point, when he told me that the Cabinet Secretary wanted to lead on the communications. The Cabinet Secretary did not want me speaking to the press or to staff until her lines had been agreed and she led them, so there would be no meetings with staff. As part of Judith's communications plan, she had a timeline for when things had to be done, people told, which is seen in **(A35827755 – Email from Judith McKay (NHS Lothian) to Chief Executive et al attaching a Comms Handling Plan - 3 July 2019 - Bundle 7, Volume 1 (of 3) – Page 71)**, but the message was that we had to wait until the Cabinet Secretary had agreed her lines. With the news that the Scottish Government would now lead on communications, I emailed Judith and advised her of the change and that things were being taken out of our hands. This is seen in my email to Judith at 2132 hours, 3 July **(A35827759 – Email from Tim Davison (CE) TO Judith MacKay et al advising timings for opening of RHCYP is too soon – 3 July 2019 – Bundle 7, Volume 1 (of 3) – Page 73).**

101. If I had been sitting in front of the press the following morning, as had been planned, I would have been saying what Fiona Mitchell, Director of Operations, had said, not what Judith had written down. I would have said that by the end of the week there would be a clearer understanding of the potential phasing of non-critical function moves and the numbers of staff involved. I would have been conveying that we had a problem, that we can't move in without fixing it because we can't move critical care and therefore a number of other services will also not be moving in. I would have been clear that we would work with clinicians to put together a re-phasing plan in the next few weeks/months. Even though Judith had the communications plan it was not set in stone, it was her trying to keep a pace with a rapidly changing environment. Communication lines can change and evolve.

102. I have been asked by the Inquiry if I had not had the conversation with John Connaghan and Malcom Wright on 3 July would the communications plan drafted by Judith have been released the next morning. I don't believe it would have.

103. I sent an email out telling staff that the timings were too early, and we would need to reassess them when we knew the government's position **(A35827759 – Email from Tim Davison (CE) TO Judith MacKay et al advising timings for opening of RHCYP is too soon - 3 July 2019 – Bundle 7, Volume 1 (of 3) – Page 73)**.

104. Confusingly, the cabinet secretary's subsequent statement to Parliament talked about a re-phased move and NHS Lothian being asked to come forward with plans for a re-phased move.

04 July 2019

105. On 4 July 2019 we were awaiting the announcement from the Cabinet Secretary. At that time I had no indication from the Scottish Government that option four for a re-phased plan (NHS Lothian's preferred option) was not agreeable and that the move was to be halted in its entirety. I was aware that the Cabinet Secretary was going to make an announcement on 4 July 2019, but we did not know what she was going to say. We were expecting to hear it from about eleven o'clock, and we kept phoning the Scottish Government and we kept being told it would be there in an hour. We were expecting it by lunchtime, and I think it came at about 4.30 in the afternoon eventually, so it was much later than expected.

106. At the RHSC at Sciennes, Fiona Mitchell and her team had organised staff briefings because people knew there was a problem because we were having all these urgent meetings. We literally had staff walking along the corridor to go into a boardroom to be updated, only for us to inform them that we had no update yet. We were waiting for the announcement and staff started hearing things and very quickly knew that there was something going on. When the Cabinet Secretary made her announcement that afternoon staff had already picked up that this was a big problem.

107. We had an expectation that we would be told of the Cabinet Secretary's decision before it went public but that didn't happen.

108. Later that evening I received a letter from Malcolm Wright **(A35827763 – Letter from Malcolm Wright to Tim Davison confirming that the Cabinet Secretary has taken the decision – 4 July 2019 – Bundle 7, Volume 1 (of 3) – Page 79)**, which I believe was the first written confirmation that the move was to be halted in its entirety. I don't think my reaction was anything other than it was the Cabinet Secretary's decision. She had made it clear she wanted to make the decision. There was a bit of a nuance between whether we have a phased move or whether we pause the whole thing and have a re-phased move subsequently, with the latter being ultimately what happened. Malcom Wright's letter also says that any re-sequencing of the move would only occur once the Scottish Government had received clearance that all technical standards had been met including lessons learned from the commissioning of the new Queen Elizabeth building. At this time, I was not aware of the lesson learnt for the Queen Elizabeth hospital nor the full extent of the issues at the hospital.

109. Within the letter, Malcom Wright notes that the decision was made following further information that emerged over the course of yesterday and last night (3 July). I have been asked by the Inquiry if I know what further information Malcolm was referring to. I don't particularly know what other information he was referring to other than the detail that had been discussed between myself and John Connaghan at the meeting held at 2pm on 3 July.

05 July 2019

110. On the morning of 5 July 2019, I chaired an internal meeting and the letter I had received from Malcom Wright **(A35827763 – Letter from Malcolm Wright to Tim Davison confirming that the Cabinet Secretary has taken the decision – 4 July 2019 – Bundle 7, Volume 1 (of 3) – Page 79)** was used as an agenda for the meeting. The minutes of this meeting are within (**A35827762 – Draft note of meeting on RHCYP/DCN Commissioning and Ventilation – 5 July 2019 – Bundle 7, Volume 1 (of 3) - Page 90)**. We were looking to address the actions that Malcolm had raised in the letter, which included transport for patients, telephone helpline and communications with patients.

The Cabinet Secretary's decision also led to the Scottish Government advising NHS Lothian that they would now be handling all communications.

111. I was surprised at that decision and thought it was unnecessary, unrealistic, and practically almost impossible. I thought at the time that it was because they wanted to have absolute control of the public messaging about the issue and I assumed this was part of the Scottish Government's tendency to micro manage and demonstrated a lack of confidence and trust in NHS Lothian's senior leadership team. I and my Communications Director did communicate this to Scottish Government but their view persisted. We were in a position where we were being instructed that we couldn't say or write anything to brief staff, without it having been prior approved by the Scottish Government. Because things were moving quickly, there were things that we wanted to say that had operational impact or that people needed to know, that were taking hours and hours, if not days, to be turned around by Scottish Government. By the time they were approved, they were out of date and the world had moved on again, which inevitably led to informal communications being relayed out to staff. I was irritated by this and surprised by it. I thought it showed a lack of trust that was unjustified. We had not done or said anything that was inappropriate and nor would we have intended to.

112. The letter from Malcom Wright also sought assurance that there were no other material specification deficiencies in the new building. I was by now aware of the issues within the Lochranza ward, but these were under an agreed derogation, and would not have stopped the move going ahead. We were not aware of any other issue that would have caused the hospital to have been delayed, and had the Critical Care issue not been identified, we would have moved in.

113. It is not accurate to say that we didn't think there were any issues. There were lots of issues, and HFS and HPS came up with a raft of issues but, none of them in our view were sufficient to have merited on their own a delay to the move, unlike the issues in Critical Care.

114. These were all issues that we believed could have been remedied while we were occupying the building and during the course of normal maintenance. We have a massive real estate in NHS Lothian, including some very modern buildings and some very old buildings, and doing major capital works within our buildings while continuing to provide services was not unusual for us. We were of the view that critical care was the only 'show stopper' issue that caused the delay, and it remains my view.

115. I have been asked by the Inquiry if the issues that were emerging at the Queen Elizabeth University Hospital were perhaps influencing some of the views held around the differentiation between what is a material deficiency, which would delay opening a hospital, and those which could be remedied when a hospital was occupied. I don't know if I can answer that, I think the only direct link that I could see was around Lochranza because learning was appearing from Glasgow. The RHCYP/DCN had already been designed and largely completed as issues arising from the Glasgow project came to light.

116. At the internal meeting on 5 July a decision was taken to set up an Incident Management Team (IMT), which later became the Executive Steering Group, with the first meeting held on 8 July 2019. When something of significance with consequences happens, an adverse event, an IMT will be set up and it's often around infection control, and this became very much about infection control and safety. An IMT is about pulling together the appropriate people with the appropriate expertise and the appropriate authority to go through a standard procedure, which is to identify the problem, the background issues, proposed actions and what happens next. The problem in this context was twofold: (1) how can we move to the new hospital; and (2) how do we sustain services in the existing sites.

117. Firstly, how do we identify a solution for Critical Care, who is going to design and complete the remedial works and how much is it going to cost. We also had to identify how long it would take to complete the remedial works, the appropriate standards etc.

118. Secondly, both the RHSC building at Sciennes, and the DCN building at the Western General had their problems, but we invested money in continuing to improve facilities to the extent that we could. We invested about £4 million across both sites, trying to improve the environment and installing new wet rooms and showers in DCN around the Pseudomonas issue. The politicians had made their decision, they were doing all the communicating, but we were still running the services and we needed to come up with a fix. I believe we were addressing those issues appropriately and, while it would have been better to have been able to move into a brand-new hospital, we believed that we were managing those two sites appropriately, given the circumstances. We were not feeling that there was an unacceptable level of risk, rather we were aware that there was risk but the risk was being appropriately managed.

119. Following the internal meeting I responded to Malcom Wright's letter by way of email, providing an update on where we were with transport, helpline and our communications plan for staff and patients **(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 (of 3) – Page 96)**.

6 & 7 July 2019

120. The weekend of 6 and 7 July 2019 followed with a number of meetings with Scottish Government. I was only able to attend the meeting on Sunday 7 July. A summary of those meetings is within **(A40988309 - Email from Tracey Gillies to Alex McMahon RHCYP/DCN Weekend Teleconference – includes topics discussed at the RHCYP.DCN weekend Teleconference – ventilation is covered - 7 July 2019 – Bundle 7, Volume 1 (of 3) – Page 149)**. My recollection from that time is that we were very much still communicating throughout that weekend, through texts, emails, or phone calls. The communication lines were open and fluid.

121. During these meetings Brian Currie, Project Director for RHCYP/DCN, was asked to explain what happened between the period of him being aware of a potential issue within Critical Care on the 24 June, and to the matter being escalated to the senior leadership team on 1 July. This is highlighted in **(A40987561 – Email from Brian Currie to Alex McMahon et al with an attachment on clinical risk assessments. Also provides reasons for derogation - 7 July 2019 – Bundle 7, Volume 1 (of 3) – Page 155)**.

122. I have been asked by the Inquiry if I was satisfied with the explanation that I was given for the delay in escalating matters to the senior leadership team. I wasn't very satisfied with anything at this point. I was hugely shocked and embarrassed by the whole thing. I couldn't believe that we had arrived at this situation. One of my responsibilities as Chief Executive was to make sure that the Project was appropriately led and resourced, and I thought it was appropriately led and resourced. We had plenty of people who should and could have picked this issue up during the Project, so I was very surprised that it hadn't been identified until such a late stage in the Project. As the subsequent Grant Thornton report at paragraph 47 **(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 11)** (see paragraph 158 below) described there were a number of 'missed opportunities' to identify the critical care ventilation problem: 'These opportunities were not identified by the clinical director for the project, the Project Director, the project team, the technical advisers, those parties involved in reference design, Project Co including Multiplex and the Independent Tester. Collectively the error was missed by all parties.'

123. Brian Currie confirmed that from 24 June he and members of the Project Team had been investigating and addressing the emerging IOM reports and that was why the critical care issue had not been escalated earlier than 1 July. There had been a history of problems with this project, and their initial view was this was another issue to identify and seek a solution for. There was the letter from Jim Crombie to IHSL a month or two earlier with a list of issues (**A41293059 –**

Letter from Jim Crombie to Wallace Weir on concerns about the progress of the Post Completion Works, Outstanding Work and Snagging Matters – 7 June 2019 – Bundle 5 – Page 101).

124. I can imagine at one level Brian was thinking this was just one more issue to resolve. I can understand that context but, in retrospect, I am also surprised that critical care wasn't raised as an issue straight away because, until that point, air change rates were never raised as an issue and all the discussions had been around air pressures.

125. I was surprised that compliance issues in the critical care design had never been picked up until IOM did their testing. I still find it astonishing that no one in the project team, the project director, the Project Board, the technical advisors, IHSL or Multiplex ever raised it at any point during the Project, and I was not really accepting of any of it at that time.

126. I was not satisfied with the explanation given and I pressed for an answer at a meeting the following week but no one could explain why we had collectively missed that IHSL had installed a ventilation system with 4 air change per hour in critical care. I kept being told that air change rates in critical care were never discussed or identified as an issue. All of the debate about ventilation had been focused on air pressure regimes and temperature but not air change rates. Maybe it was simply being overwhelmed by masses of data and not being able to see the wood for the trees but neither the KPMG or Grant Thornton (see paragraphs 151 and 152) investigations really got to the bottom of why air change rates had not been identified as a major problem.

Site Visit

127. On 9 July 2019 the Cabinet Secretary, Malcolm Wright, and Catherine Calderwood (Chief Medical Officer), carried out a site visit to the RHSC at Sciennes, where they met the Chair, Brian Houston and me. I recall this meeting as being extremely frosty. The Cabinet Secretary opened it in a way that expressed her dissatisfaction with the whole situation with the

RHCYP/DCN and threw the ball to us to say something in response. My chairman started by saying how sorry we were that it had happened and how shocked we had been about it, and he invited me to brief her on our understanding of what had happened and why, and what we were doing about it.

128. However, because I had been briefing John Connaghan and Malcolm Wright and others about everything that was happening, and they had already briefed her, she knew pretty much everything there was to know. She was dismissive of what I was telling her and just kept saying, "I know all that''. So, the meeting didn't really go well, and then she expressed her view that it was the Board's failure and in particular a failure of governance. I believed that it was premature for the Cabinet Secretary to have come to that conclusion which appeared to ignore the roles and responsibilities of all parties involved in the project including our technical advisors, IHSL and Multiplex. KPMG's review of governance carried out subsequently confirmed that appropriate governance systems were in place and that they operated as they were designed to do.

129. The Cabinet Secretary had arranged the visit to meet my staff, but had deliberately excluded us from the walkaround, which was unusual. The Cabinet Secretary had recently visited our services on a couple of occasions, and those visits would had been hosted by me or by one of my senior team, and we accompanied the Cabinet Secretary as she walked around and talked to staff. The fact that she was excluding us, so it was the local team managing the hospital who were showing her around, rather than the leadership of the Board was irregular, and I was disappointed by that.

Executive Steering Group

130. I have been asked by the Inquiry what the IMT achieved. The IMT became the Executive Steering Group (ESG). The ESG was a forum which brought together all of our key internal, managerial, advisory and clinical people to try and come up with the fix to the problem, to assess the HFS/HPS reviews. The ESG terms of reference state **(A41348347 - RHCYP and DCN Exec Steering**

Group Terms of reference - 23 August 2019 – Bundle 13, Volume 4 – Page 88).

'To provide a forum for NHS Lothian executive management to consider all business relating to responding to and addressing the delay to the Royal Hospital for Children & Young People and Department of Clinical Neurosciences.

The work of the executive steering group will inform what NHS Lothian executive management provides to and responds to:

- *The Scottish Government Oversight Board: Royal Hospital for Children & Young People, Department of Clinical Neurosciences and Child & Adolescent Mental Health Services (Oversight Board).*
- *The NHS Lothian Finance & Resources Committee.*
- *The NHS Lothian Healthcare Governance Committee*
- *Lothian NHS Board.*

The Royal Hospital for Children & Young People and Department of Clinical Neurosciences Programme Board will address issues relating to communicating with staff and managing contingency arrangements in the period until it has been confirmed when the transfer of services will occur.

Once the Scottish Government Oversight Board has confirmed that the transfer of services can occur, the Royal Hospital for Children & Young People, Department of Clinical Neurosciences Programme Board will resume responsibility for the planning and management of the transfer. At this point the executive steering group will cease to meet.'

131. The ESG coordinated all of the work that was being done to try and identify solutions to the problem. It allowed us an opportunity to discuss things that were then being fed into the Scottish Government's Oversight Board and to discuss decisions that had come out of the Oversight Board and work out how

best to deal with them. Even with the Oversight Board, NHS Lothian were party to the contract with IHSL, and subsequently for the remedial work, therefore NHS Lothian were the party legally responsible for the resolution we were effectively doing most of the work.

132. Along with coordinating all of that the work, the ESG was providing a conduit between NHS Lothian Board and Scottish Government's Oversight Board, and also between NHS Lothian's executive team, the Project Team and all the advisors. We could then link as required into the Finance and Resources Committee, or the NHS Lothian Board, or to the corporate management team as required. It was a method of synthesising, pulling together and overseeing, both up and down, between the Oversight Board and others to monitor what was going on.

133. The ESG was largely chaired by Professor Alex McMahon (Nurse Director), or by Susan Goldsmith (Director of Finance), or Tracey Gillies (Medical Director) in Alex's absence.

134. I attended the ESG meetings as I felt very responsible for the whole thing, and I wanted to support my team, and felt that particularly with Jim Crombie being off for months on sick leave, that I should continue to be very directly supporting my team and I did.

Design Development of Solution

135. I have been asked by the Inquiry for my thoughts on how the design development should have progressed and the development of the solution. I was clear that we needed to have HFS and HPS, the Oversight Board and ultimately the Cabinet Secretary signing off along the way and that, unless they'd signed it off, we were not going to move forward. I think there was a nervousness on my behalf that perhaps not everyone was learning the lessons as quickly as I thought they should be and that all solutions needed to be approved

136. My concern was that we'd had huge problems with IHSL and with Multiplex, and that continued. We had difficulties in getting IHSL to design and deliver the remedial ventilation works. IHSL would not agree to the high value change under the Project Agreement without significant indemnities. This was also the case with IHSL's supply chain partners, Multiplex (Construction Contractor) and Bouygues (FM Contractor). Eventually IHSL managed to get their supply chain sorted out, but only by bringing in a new contractor, Imtech, to the process instead of Multiplex. I was not involved in the detailed discussion or negotiation around that but was aware of it due to my position on the Executive Steering Group. Susan Goldsmith led the commercial discussions with IHSL along with support from Iain Graham, Mary Morgan (Senior Programme Director appointed by the Scottish Government) and Peter Reekie from SFT.

Escalation to Level 3

137. On 12 July 2019 I received a letter from Malcolm Wright (Director-General of Health and Social Care and the Chief Executive of NHS Scotland) informing me that Lothian Health Board had been escalated 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 (of 3) – Page 339)**. I have been asked by the Inquiry my thoughts on why the Board was escalated.

138. I was surprised that we were escalated and surprised at the timing of the escalation. There were a number of health boards which had been escalated before us including Tayside, Ayrshire and Arran, Forth Valley, Borders, and Highland, so the fact that the NHS in Scotland was facing major performance challenges was not unknown. However, all of the issues that were escalated we had been raising with Scottish Government for a number of years, so we knew where the problems lay, and the main problem in NHS Lothian was a lack of capacity. The growth in demand for our services had exceeded the growth in our capacity to respond for many years.

139. We had the lowest target per capita funding in Scotland, and we never actually achieved parity with our target funding so we were hit by a double whammy of below average target funding and also below parity allocations. NHS Scotland uses a resource allocation framework based on weightings designed to reflect need. Some health boards have a target allocation greater than the average allocation per capita and some have a target allocation that is at the average or below it. NHS Lothian had the lowest (along with Grampian) target allocation per capita for all of my time there – our target allocation was circa 90% of the Scottish average target allocation. The formula is recalculated each year based on population changes and this results in some boards moving further away from parity or nearer to parity depending on whether their share of the total population has grown or fallen. NHS Lothian had the fastest growing population share in Scotland and this meant that our annual funding allocation failed to keep pace with our population growth and so we never actually achieved our target allocation despite receiving additional funds each year to keep us within 1% of our target allocation. We were usually £7m or more adrift from parity in absolute terms. Over time, this compounding of below average target funding combined with below-target allocations left the board with a serious imbalance between demand and capacity and contributed significantly to the pressures that our services experienced with inadequate capacity which led to the escalation for waiting times, delayed discharges, mental health services etc. All boards experienced these pressures to some extent or another but I felt that Lothian was starting from a relative low base of below average target funding which in itself was never fully provided by the Scottish Government.

140. We expressed our concerns about a lack of capacity to the Scottish Government throughout my time in NHS Lothian. I was brought into NHS Lothian by the Scottish Government because of a waiting times scandal that was all about Lothian masking the extent of the problem that it had in meeting waiting times. They had been struggling with waiting times for probably 20 years, and we had been raising the need to not only at least receive our full target allocation but also to get ahead of the allocation each year to anticipate

the forecast growth in our population. We wanted to get ahead of the population curve and not constantly be trying to catch up with it.

141. We made that case because we felt that it was our duty to raise that on behalf of our population but, the Scottish Government, in my view, became irritated by us stating our view about that, and their preferred view appeared to be to just regard our performance challenges as being reflective of poor management and that we should just get on and sort it out. So, there was always a bit of a tension between us because of that.

142. I believe our performance on most of the areas that we were being escalated on had significantly improved compared to 12 months previously. The scheduled care activity was ahead of the trajectory we had agreed with government about where we needed to be. Our unscheduled care performance, which was around the four hours emergency access standard was significantly better than a year previously – up to 93% and our delayed discharge performance became in line with all-Scotland performance through a combination of our numbers reducing and numbers in other boards increasing. We had 101 delayed discharges fewer in July 2019, compared to the previous year. We were not suggesting that we didn't have major performance and capacity challenges, we did, but I was surprised at the escalation given Malcolm's letter itself acknowledged improvements in performance in several areas.

143. I think there was a view in Scottish Government that escalation could be seen as a positive thing, that a health board was being given additional support. I can tell you that health boards didn't regard it like that and we regarded it as being punitive and undermining.

144. I was also surprised that NHS Lothian was being escalated, yet Glasgow wasn't because Glasgow and Lothian are by far and away the biggest health boards in population terms and Glasgow was equally, if not more, challenged by performance in a number of these areas. That felt odd to me, not only was it odd that they escalated Lothian, but it was odd that they escalated us and not Glasgow. Glasgow was subsequently escalated as well, and we ended up with

something like three-quarters of the Scottish population being served by health boards under escalation.

145. The Scottish Government had justified the escalation on the basis of the cumulative impact of our issues, together with the significant work required to complete the move of the new RHCYP/DCN. They felt that this would place significant pressure on the leadership capacity of NHS Lothian. The situation with RHCYP/DCN was ultimately handled and resolved.There were lots of issues to manage and we managed them, and I don't believe that escalation was required, and I was surprised at the timing of it.

146. The practical consequences of the escalation was that it essentially creates a focus and a very regular and in-depth scrutiny between the Scottish Government and me, personally, with my executive team, on coming up with plans to address the problems and hopefully progress towards achieving them. There were weekly meetings where we would go to the Scottish Government and account for what we were doing with regard to delayed discharges and four hours' waiting times and cancer treatment. The escalation gives it a focus, not that we wouldn't have had that focus anyway, but nevertheless, it gives it a focus.

147. It also provided us with some additional resource to appoint two or three senior people to come and help us with these issues, so that was not unhelpful. As it happened, a designated Scottish Government director was appointed to oversee the escalation, and John Connaghan was appointed as the director, and he was very helpful and very constructive. I didn't like being escalated and I didn't think we needed to be but he undertook that role very constructively and positively and we did improve up until the COVID pandemic. Most of the services covered by escalation had already been improving compared to the previous year prior to escalation and so this was a continued trend of improvement post escalation.

148. Although I was surprised and disappointed to have been escalated, I was a professional Chief Executive, and I responded to it professionally. We wanted things to improve and we responded professionally. It is not good to be under

special measures, and the press caricature of that is that management is underperforming. I still think that NHS Lothian does not have enough capacity to deal with its population. It needs more beds, more diagnostic capacity, and it needs a greatly improved social care infrastructure.

Escalation to Level 4

149. The escalation to level 4 was for RHCYP/DCN Project only. I felt this was different because the Cabinet Secretary had in effect taken personal control of the decision making and appointed an Oversight Board **(A41231071 – Attached Malcolm Wright letter – 13 September 2019 – Bundle 13, Volume 4 – Page 90)**. So my view was that for the Project, we were in effect already at escalation 4 before it was formalised as it already been implemented on 2 July or 3 July when the Cabinet Secretary said that she was making all the communication decisions and all of the subsequent decisions about when and how the hospital was occupied. Whereas the escalation to level 3 for services had come as more of a surprise.

150. The Oversight Board became necessary because the Cabinet Secretary had escalated us to Level 4 for the RHCYP/DCN Project. The Cabinet Secretary was making the decisions and therefore required her civil servants to be directly involved.

151. The escalation to Level 4 for the RHCYP/DCN led to the appointment of Mary Morgan as Senior Programme Director by the Scottish Government. I assumed that the Scottish Government had lost confidence in me and our team's ability to deliver the Project, and that they wanted to bring in fresh eyes and no baggage associated with the Project. I don't think it's fair that the Cabinet Secretary should have lost confidence in us, but I think it's fair that thinking bringing in some fresh eyes and some additional experienced project management capacity would be helpful. Mary Morgan was appointed, and she did do a good job and was very professional with us.

152. We would speak frequently, and she integrated into our team well and we treated her with respect and professionalism, so there was no resistance from

NHS Lothian. (The DCN/RCHYP Project Governance schematic dated 17 October 2019) **(A41348350 – Sec21 B 00005010 - Bundle 13, Volume 4 – Page 93)**. Even though we were not happy with the situation we found ourselves in, the bottom line is we wanted to fix the problem, we wanted to open the hospital, and Mary was going to help us achieve that. So, we welcomed her and she worked well with us and was very helpful.

153. Mary Morgan's role as the Senior Programme Director was to report directly to the Oversight Board but NHS Lothian remained legally and contractually in charge of the Project. I was still the accountable officer. Even though the decision-making for that particular Project had been removed from me, I was still accountable for what the Health Board was approving, in terms of the spending of public money. If the Oversight Board agreed to do something that I thought was a misuse of public funds, I would have intervened but that eventuality did not occur.

Reports

NSS Reports

154. After the identification of the issue in critical care, the Scottish Government commissioned reports from NSS (the NSS Reports) to review the water, ventilation, drainage and plumbing systems at RHCYP/DCN (**A41213257 – Part B 5.6-20190909 NSS Audit Report – Bundle 13, Volume 4 – Page 95)**.

155. I have been asked by the Inquiry for my thoughts on the findings of the NSS reports. I had no personal involvement in any of their work as they were working at a technical level and working very much with our technical people, however, I think it was generally helpful having HFS/HPS/NSS involved. I do think that they were introducing things that perhaps went beyond what we thought was strictly necessary, e.g., the fire prevention matters, which were improvements rather than remedying defects and we had already received a fire certificate for the building.

156. Although there were a lot of issues that we needed to look at and there was work to do, there was nothing that jumped out from the NSS Reports that suggested that there was another game changer other than Critical Care.

KPMG Report

157. NSS commissioned KPMG to independently establish the facts around the decision to delay the move to the Hospital and review the governance arrangements (the 'KPMG Report') **(A32512397 – KPMG Report – Independent Assessment of Governance Arrangements – 9 September 2019 – Bundle 13, Volume 3 – Page 1153).** As part of the evidence gathering for the KPMG Report, KPMG spoke with a number of parties along with individuals from NHS Lothian. I was involved as I was personally interviewed at length at least twice by KPMG. Their report was an uncomfortable read because we shouldn't have been where we were, but I thought they described what had happened and how it had happened very accurately and helpfully.

Grant Thornton Report

158. NHS Lothian commissioned Grant Thornton to conduct a review of the governance and internal controls over the RHCYP/DCN Project (the 'Grant Thornton Report') **(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 11).** I met the author of the Grant Thornton Report several times. I was present at Finance and Resources Committee when the report was presented in various draft stages. I do agree with the report and its findings. I was on leave from 24 June 2019 until my retirement in August and so I missed the presentation of the final version and was not around for its implementation.

Media Interest

159. Up until the point that I had retired both STV and BBC sought an interview with me, along with a few newspapers. Before speaking to the media, I had to clear it with Scottish Government. I was interviewed by The Scotsman and the

Evening News and by STV and the BBC, both of which were shown on their television news programmes.

160. I was grilled intensively about the RHCYP/DCN, and kept getting asked, “Are you going to resign because of this?” My answer at the time was, “Well, not right now I’m not. Right now, my focus is on supporting my team and trying to get the thing fixed.” That was my view.

161. Ideally, I wanted to be there to see the hospital open. In the event I retired a few weeks before the first phase of the move took place, but I was confident that the hospital was going to open as planned. There were lots of other reasons and personal reasons why I wanted to retire, but I stayed for a year after the debacle of 1 July 2019 to oversee and support my leadership team. What eventually happened in August 2020 was what we had discussed as our preferred option on 2 July 2019, i.e fixing the problem and moving in, in a phased way. It took longer and it cost more than I would have liked, but it happened. The hospital is a great hospital and it is doing a good job.

Reflections

162. I have been asked by the Inquiry if I felt that the Scottish Government’s position that DCN and other services could not move until NSS had carried out their review caused an unnecessary delay in the transfer of those services. I think that’s very difficult for me to answer. The patient risk at DCN was being managed and I can understand why Scottish Government took that decision, as there were lots of uncertainties and unknowns at the time. It would appear that the Scottish Government did not want any more shocks and wanted all I’s dotted, and T’s crossed before we occupied the building.

163. I think that it was a legitimate decision and that’s what I said at the time. It wasn’t my preferred option, and I would have gone with moving DCN earlier and I believe most of my team would have moved DCN earlier. The word “unnecessary” is a subjective word because it’s a fact that it caused a delay. The government obviously thought that it was a necessary delay to give them confidence in the opening of the hospital.

164. I have been asked by the Inquiry what critical factor I think led to the Critical Care issue going unnoticed until days before the planned opening date. There were a number of critical factors but the fact that the Critical Care Unit comprised lots of different room types that were also provided elsewhere in the hospital seem to confuse people and lead to different interpretations of Guidance. The Critical Care Unit had four bed bays, but there were other four bed bays in the hospital. The Critical Care Unit had single rooms, but there were lots of single rooms elsewhere within the hospital. It was only the Critical Care and Haematology that had the isolation rooms, there was a much smaller number of that type of rooms. I think if someone had been able to literally put a red line around the Critical Care Unit and said, "The 24 beds in this room, just for the avoidance of doubt, are all to be at 10 air changes an hour with a negative or balanced pressure regime," that could have prevented the problem from happening.

165. There were 11 revisions of the environmental matrix and there was one revision in which the guidance note which stipulated all of critical care needed 10 ACH was changed by IHSL so that it was applicable to "isolation rooms only." If that change by IHSL had been flagged to NHS Lothian and MML then NHS Lothian could have clarified that they wanted all rooms in critical care to have 10 ACH, as per the guidance note. So, that was the seminal point at which someone involved in the project both internal and external should have said, "There's a contradiction here." If that had been raised, then the problem would have been avoided because we could have dealt with it.

166. Another opportunity was at the point that the derogations were agreed and someone could have said, "Are you sure about this derogation to 4ACH and negative pressure in multi-bed rooms in critical care, do you know that's a derogation to guidance?" and we'd have said, "Of course we're not sure." We then would still have had to spend the £11.6 million, and it would have taken months to resolve, but at least we would have known about it at that point rather than waiting months later. So, I think if you had a magic wand, you would change those things. But as I stated earlier I agree with KPMG and Grant Thornton Reports that it was a collective failure.

167. I also think the relationship between the built environment and the infection control agenda, whether that be water systems or ventilation, needs to be elevated in a way that it is almost ring-fenced so that regardless of what a project agreement might say or a contractual negotiation might say, these are the de minimis requirements that we must not breach. That would be helpful.

168. Regrettably, humans make mistakes, and the KPMG report, I thought, was quite helpful in saying there was no evidence of malice, there was no evidence of criminality or wrongdoing. There were lots of people involved in this project who should and could have at least questioned why the environmental matrix kept changing. To think that Multiplex, who had just built a billion-pound hospital in Glasgow, would think that our critical care unit included just four isolation rooms at 10 ACH is more than surprising and, at the very least, they should have clarified this with us. Yes, they arguably secured some derogations for critical care in SA1, but they had designed and installed the ventilation system in critical care years before SA1 was agreed.

169. I hugely regret the issue with RHCYP/DCN and regret the delays and the cost of it. However, in the interest of fairness and to assist with learning, I believe it should be recognised that our project was by no means unique in running in to delays and cost overruns. There has been a history of significant problems with large scale capital investment public infrastructure projects in Scotland and the costs of our project look relatively small compared to many others. It does make me think that there may be lessons more broadly about running these big projects that extend beyond our own project.

170. I have been asked by the Inquiry what actions I consider would have mitigated the risk of the ventilation issue within Critical Care leading to a blanket delay of opening the whole build. From what I know now, I think if we hadn't used the reference design and had just stuck with the Board's Construction Requirements (BCRs), which were clear about complying with SHTM 03-01, that would have helped. The reference design allowed a confusion that I think could have been avoided.

171. I still think there was plenty of opportunity for people to have highlighted that the Guidance states there should be 10 ACH whereas your reference design says something else. At the very least, someone should have flagged that contradiction and asked NHS Lothian to confirm what air change rate was required. One of the reasons for using a reference design was to illustrate the clinical adjacencies which had been so time-consumingly agreed with senior clinicians and that was important, but perhaps we should not have included any technical documentation whatsoever to avoid any dubiety. Maybe doing so blurred the lines between our previous design responsibility and the new design responsibility and design risk transferred to the project company.

172. I think if we had properly risk-assessed the shift from a capital-funded project to a private finance project, which was a design and build where the transfer of risk around the design was to be handed over to the company delivering the project, I think that may have helped. We did obtain advice from our technical advisors as to the use of the reference design and our procurement options but NHS Lothian had a very limited time to update and produce the outline business case for the joint project and proceed to procurement in a short timescale as required under the funding conditions. This resulted in limited time to prepare a thoughtful risk assessment of the change in procurement methodology.

173. I also think it would have been helpful for us to have had a better independent assessment of the consequences of our agreed derogations on technical guidelines and requirements, such as SHTMs, before the derogations were finally agreed. This advice could (and should) have been provided via our technical advisors, MML, or an independent body such as HFS could have been consulted. Even if that had happened in 2018/2019, we wouldn't have avoided the problem, because the problem was already implemented. IHSL had already designed and installed a ventilation system that could only deliver four air changes. Nevertheless, we would have found out about it sooner.

174. I think there's another action that might have helped, and there was some talk of it before I retired, which is that for complex projects like this it would be helpful to have as a nationally organised resource, a cadre of senior, experienced people to lead the most complex and larger scale projects on behalf of health boards. I have been a Chief Executive in five organisations, operating in that role for 26 years, and have been responsible for hundreds of millions of pounds of capital investment projects, but I had never been responsible for a project as complex as this, nor with a financial, contractual and legal framework like this.

175. I have been asked by the Inquiry how satisfied I was with how Lothian Health Board handled matters following discovery of the Critical Care issue. I think it was handled very well and very professionally. Nothing should diminish how shocked and sorry we were that this happened. None of us took it lightly. Although I have said that financially the consequences of this were much smaller than lots of other capital projects in Scotland that have gone wrong, that is not in any way to diminish that I wish that this had not happened. I really am sorry, I regret it deeply, but mistakes happen. The Edinburgh trams happened, the Scottish Parliament building happened, the Aberdeen bypass happened, the ferries are happening and so, therefore, as public sector organisations and as human beings, we have clearly the capacity to make mistakes and often have problems with these big capital projects.

Declaration

176. 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.