Scottish Hospitals Inquiry
Witness Statement of
Malcolm Robert Wright OBE

Introduction

1. My name is Malcolm Wright. This witness statement is being provided for the Scottish Hospitals Inquiry "Glasgow IV" hearings. It follows and, where appropriate, expands upon the witness statement that I provided to the Inquiry for the Edinburgh hearings commencing in February 2024 ("Edinburgh IV hearing").

2. I remain retired and refer to my previous statement and the CV appended thereto in relation to my personal details and professional background.

3. I held the role of Director General for Health and Social Care ("DGHSC") and Chief Executive of the National Health Service in Scotland between 11 February 2019 and 31 July 2020. I was absent between 22 April 2020 and 31 July 2020 (when I retired) due to a period of sick leave. I refer to my earlier statement (paragraphs 3 to 16) for the circumstances of my appointment, the scope of my responsibilities, who I reported to and those who reported to me.

4. To expand upon the information that I have previously provided about the scope of my responsibilities, I would take this opportunity to set out the unique nature of the job role of DGHSC and Chief Executive of the NHS Scotland in both the Scottish Government and the wider public sector in Scotland. The role reported to the Permanent Secretary and was one of six Directors General within the Scottish Government. In this capacity I met with the Permanent Secretary and other Directors General on a weekly basis as part of the Permanent Secretary's Executive Team, with a focus on the delivery of the Scottish Government's National Performance Framework and the mobilisation and development of the civil service in Scotland to support the First Minister and Cabinet in the delivery of their priorities and Programme for

Government. I had monthly one-to-one meetings with the Permanent Secretary. The role required the development of and extensive collaborative network of working relationships across partner agencies, professional and regulatory bodies and staff organisations. The DGHSC is the Scottish Government's principal policy advisor on health and social care. The position also incorporates the role of Chief Executive and Accountable Officer of the NHS in Scotland. The (then) 22 individual health boards in Scotland in turn have their own chief executives, who are their Accountable Officers. The Chief Executive of the NHS in Scotland does not line manage health board chief executives; rather they report to health board chairs, who in in turn are directly appointed by and accountable to the Scottish Ministers. The Scottish Ministers hold the NHS Boards to account through annual and mid-year reviews conducted with board chairs and chief executives; and this is a process in which the DGHSC and senior Scottish Government officials are normally present alongside the Cabinet Secretary. In this context, I participated in NHSGGC's annual review on 11 March 2019 and mid-year review on 24 October 2019, led by the Cabinet Secretary.

5. The purpose of my role as DGHSC was to work directly with the Cabinet Secretary on the strategic and wider work of the Scottish Government in relation to Health and Social Care and to ensure the performance management of the 22 NHS Boards. A key aspect of that role was advising, enabling and assisting the Cabinet Secretary in furtherance of her priorities and ensuring that she had all of the necessary advice and information that she needed to make decisions. During my appointment as DGHSC, the remit for the role had a strong emphasis on a Scottish Government-wide corporate contribution, particularly through membership of the executive team, corporate board and leading cross-departmental work in government to deliver the outcomes of the national performance framework. There was also a strong emphasis on strategic change and the delivery of the Cabinet Secretary's priorities of waiting times, mental health and the integration of health and social care, together with establishment of Public Health Scotland, with a focus of driving forward the improvement of the health of the Scottish population. I required to provide strategic direction to NHS Scotland and drive

performance, efficiency, value for money and the delivery of sustainable high-quality services – acting as Accountable Officer for the portfolio budget. I had weekly one-to-one meetings with the Cabinet Secretary.

6. There were nine direct reports to the DGHSC when I held that post. Those were: the Director of Performance and Delivery, John Connaghan; the Chief Medical Officer, formerly Catherine Calderwood, and latterly Gregor Smith; the Chief Nursing Officer, Fiona McQueen; the National Clinical Director, Jason Leitch; the Director of Health Workforce, Shirley Rogers; the Director of Finance and Infrastructure, Christine McLaughlin; the Director of Health and Social Care Integration, Eleanor Mitchell; the Director of Mental Health, Donna Bell; and the Director of Population Health, Richard Foggo, who was responsible for public health, health improvement, primary care, and setting up of Public Health Scotland, which was a major development at the time. Those direct reports met with the Cabinet Secretary, along with me, in person on a weekly basis following the Cabinet meeting. I would also meet with all of the Directors within the Health and Social Care Directorate on a weekly basis at the Health and Social Care Management Board ("HSCMB"). The Cabinet Secretary would attend the HSCMB from time to time, providing her with a further opportunity to meet with the Directors from the Health and Social Care Directorates. These meetings were in keeping with the objectives within the Scottish Government to remove organisational boundaries supporting the leadership role of directors, who are fully authorised and expected to work directly with and support Ministers in achieving their objectives. The Cabinet Secretary and the DGHSC Team would highlight the topics for discussion each week and her direct reports would brief her on these. I recall the QEUH/RHC being featured in these discussions. I met collectively with the NHS Board Chief Executives on a monthly basis to discuss and drive forward ministerial strategic and performance priorities. As DGHSC, I made a point of visiting Health Board areas across Scotland to see NHS Facilities first hand and meet with frontline and Senior Staff, including Integration Joint Board colleagues and local authority Chief Executives.

Awareness of Concerns at the Queen Elizabeth University Hospital ("QEUH") and Royal Hospital for Children ("RHC") in February 2019

7. I was immediately made aware of concerns at the QEUH and RHC when I started in post in February 2019. I was provided with a handover from my predecessor, Paul Gray, which included a briefing on the emerging concerns at the QEUH and RHC about the built environment and infection prevention and control. The handover briefing made me aware of the Cabinet Secretary's visit to the Queen Elizabeth with the Chief Nursing Officer ("CNO") and National Clinical Director ("NCD") on 21 January, the Cabinet Secretary's briefing to the First Minister of 23 January, the events leading to the Cabinet Secretary's statement to the Scottish Parliament on 26 February and the publication of HPS report on 22 February 2019.

8. I was also aware that my predecessor, Mr Gray, had met with the Chief Executives and Directors of Estates of all Health Boards in Scotland on 22 January 2019 (shortly before I took up post) to brief them on the emerging issues at the QEUH and RHC and to seek assurances, through Health Facilities Scotland ("HFS"), about the maintenance and testing of ventilation and water systems, as well as plant rooms within their acute estate **(Bundle 4, Document 3, Page 8)**. The Inquiry already has evidence before it as to the intention behind and required actions flowing from Mr Gray's letter of 25 January 2019, which was issued to the Directors of Estates of all Health Boards in Scotland. In brief, the letter included a section relating to assurances being sought that all critical ventilation systems were being inspected and maintained in line with SHTM 03-01. The letter was sent in order to obtain assurance in that respect from all health boards in light of the emergent issues and concerns at the QEUH/RHC. The letter required responses to be directed to Health Facilities Scotland, who were tasked with monitoring the situation. The former Cabinet Secretary, Ms Freeman, explained to the Inquiry within her principal witness statement for the RHCYP/DCN hearings, at paragraphs 34 to 37, what she had instructed Mr Gray (and through him HFS) to do. I do not have documentation available to

me from the Inquiry that would allow me to comment upon NHSGGC's response to HFS.

9. Upon coming into post, I had a number of initial conversations with the then Cabinet Secretary for Health and Sport, Jeane Freeman, who spoke of the concerns at the QEUH and RHC and the high-priority being given to addressing them.

10. I also met with all of the Scottish Government Directors, who reported to me, including the then CNO, Fiona McQueen, who was the Policy Lead for Healthcare Acquired Infection ("HAI"); the then Chief Medical Officer ("CMO"), Catherine Calderwood; and then Chief Finance Officer, Christine McLaughlin, who had within her remit the brief for the built environment and Capital Investment Group ("CIG"). Thereafter, I met with them weekly as a team (as mentioned above) and also had monthly one-to-one meetings with them throughout my time in post. This was part of a planned, systemic pattern of engagement, which enabled me to be kept informed and support action across a wide range of areas in NHS Scotland in constantly changing circumstances.

Escalation of NHS Greater Glasgow and Clyde ("NHSGGC") Health Board on the NHS Board Performance Escalation Framework

11. I provided detail about the NHS Board Performance Escalation Framework ("the Escalation Framework") **(Bundle 13, Volume 3, Document 18, Page 683)** in my earlier statement for the Edinburgh IV hearings and refer to that for an explanation of the process.

12. When I came into post, NHSGGC was at Stage 2 of the Escalation Framework. On 22 November 2019, I took the decision to escalate NHSGGC to Stage 4 of the Escalation Framework. I set out the decision and reasons for it in writing in a letter to John Brown, Chairman; and Jane Grant, Chief

Executive of NHSGGC dated 22 November 2019 **(Bundle 52, Volume 1, Document 23, Page 310)**.

13. The reasons for my decision to escalate NHSGGC to Stage 4 of the Escalation Framework, specifically focussed on the systems, processes and governance in relation to Infection Prevention Management and Control at the QEUH/RHC and the associated communication and engagement issues, are consistent with those in the paper considered by the HSCMB on 22 November 2019. To summarise, the concerns that led to this recommendation were centred around infection prevention and control within the QEUH/RHC and the perceived need to support the Board's engagement and communications in relation to that.

14. The decision on escalation of a Health Board to Stage 4 on the Escalation Framework sits with the DGHSC/ Chief Executive of NHS Scotland. I did not make the decision to escalate NHSGGC in isolation. The impact of escalating a health board is serious, and so I did not take such a step without first seeking advice and consulting with the Cabinet Secretary. I took advice from the HSCMB, who met on 22 November 2019 and who recommended that NHSGGC should be escalated from Stage 2 to Stage 4 **(Bundle 52, Volume 1, Document 6, Page 34)**. In this instance, the recommendation and supporting paper was prepared by the CNO as the policy lead for HAI, who had discussed this with me prior to the paper being presented.

15. The Cabinet Secretary was regularly briefed about the issues within NHSGGC and, specifically, the QEUH/RHC prior to the decision to escalate to Stage 4 through a constant flow of information from Scottish Government Directors, including the CNO. It was standard practice for me to be copied into all written briefings that went to the Cabinet Secretary's office, most of which were prepared by staff within the CNO Directorate. The Inquiry has been provided with copies of these written briefings. Additionally, the Cabinet Secretary had regular direct discussions with the CNO and other Scottish Government Directors and Deputy Directors about these matters. This issue

featured in the regular weekly meetings led by the Cabinet Secretary with DGHSC directors.

16. As Policy Lead for HAI/ IPC, the CNO had responsibility for the Scottish Government's liaison with the NHSGGC Board in relation to infection prevention and control. Staff within the CNO Directorate were also in direct contact with HFS and Health Protection Scotland, who were also liaising with NHSGGC regarding individual incidents and the follow up work in relation to those. There was also intelligence coming to the Cabinet Secretary via the CMO's updates, which contained information received from medical colleagues in NHSGGC.

17. The Scottish Government had also appointed Professor Craig White on 4 October 2019 to lead and direct work in relation to communication and engagement between NHSGGC and affected patients and families at the QEUH/RHC. I am aware that the Cabinet Secretary would hold regular meetings with him, as well as the CNO and CMO. By the point of escalation, Professor White was providing Scottish Government officials with important information about his contact with the Board of NHSGGC, staff and affected patients and families, which was leading to rising levels of concern about the extent to which NHSGGC had a proper grasp of the issues at the QEUH/RHC (which are drawn out in the HSCMB paper referred to at paragraph 14 of this statement, above) and engaging and communicating effectively with families and clinicians.

18. All of these factors led to increasing levels of concern within the Scottish Government about the issues at the QEUH/RHC and the apparent need for government intervention. Whilst the decision to escalate a Health Board to Stage 4 is not a Ministerial one, I discussed the recommendation with the Cabinet Secretary as well as with the CNO, both of whom agreed that it was appropriate.

19. As I have mentioned, there were increasing levels of public concern in the matters at the QEUH and RHC at this time and I am aware that elected

representatives were also playing a role in expressing their constituents' concerns within the Scottish Parliament about infections and the built environment of the QEUH/RHC and the Board's handling of these issues.

20. The timing of the escalation was directly linked to the information highlighted within the escalation paper. In addition to the public concerns being generally expressed about the issues at the QEUH/RHC, by the point in time of the meeting of the HSCMB the Cabinet Secretary had met with families and patients (on 29 September and 1 October) and heard their specific concerns. Feedback had also by then been obtained from Professor White in relation to the operation of NHSGGC's incident management team, including clinical concerns and concerns as regards communication, engagement with patients and clinicians and transparency in relation to decision-making. That information was significant in the consideration of whether NHSGGC required an increased level of intervention and support. When the decision was made to escalate the health board to Stage 4 of the Escalation Framework, I wrote immediately to the Chair and Chief Executive of NHSGGC to inform them of the position **(Bundle 52, Volume 1, Document 23, Page 310).** That same day, the Cabinet Secretary made a full statement in the Scottish Parliament about the decision to escalate **(Bundle 52, Volume 1, Document 25, Page 315)** and wrote a letter to the Chair of the Scottish Parliament's Health and Sport Committee **(Bundle 52, Volume 1, Document 26, Page 324).**

21. The establishment of the Oversight Board ("OB") was one of the most important steps taken by the Scottish Government upon escalation of NHSGGC to Stage 4 and is consistent with the Escalation Framework objective of providing appropriate support and intervention to address the concerns that had led to the escalation.

22. The OB reported to me. In consultation with the Cabinet Secretary, I appointed the CNO, Professor Fiona McQueen, as the Chair of the OB as she was one of the Scottish Government's most senior professional Directors. The membership of the OB also included other relevant senior professionals, including, Keith Morris (Deputy Chair - Infection Control Doctor Advisor,

Scottish Government Chief Nursing Officer Directorate), Professor Hazel Borland (Executive Director of Nursing, Midwifery and Allied Health Professions & Healthcare Associated Infection Executive Lead, NHS Ayrshire and Arran), Professor Craig White (Divisional Clinical Lead, Healthcare Quality and Improvement Directorate, Scottish Government), Dr Andrew Murray (Medical Director, NHS Forth Valley and Co-chair of Managed Service Network for Children & Young People with Cancer), Lesley Shepherd (Professional Advisor, CNOD, Scottish Government), Alan Morrison (Health Finance Directorate, Scottish Government), Sandra Aitkenhead (CNOD, Scottish Government (secondee)), Greig Chalmers (Interim Deputy Director, Queen Elizabeth University Hospital Support, CNOD, Scottish Government), Calum Henderson (Secretariat – CNOD, Scottish Government) and Professor John Cuddihy (Families representative). Within the OB, three sub-groups were also established and chaired. Both the OB and its sub-groups were intended to be a vehicle to rigorously manage the emerging situation at the QEUH/RHC. It is worth noting that membership of the groups is external to NHSGGC and that NHSGGC senior staff are observers.

23. The CNO was selected as the Chair of the OB for a number of reasons. The CNO was the policy lead for HAI, as well as an expert, very senior and highly respected clinician who would command confidence with the clinicians and the senior leadership team with whom she was working, both within the Scottish Government and NHSGGC. In my view, the CNO was a very strong appointment; and the decision to put the Scottish Government's most senior IPC leader in to direct this work, in my view, sent a signal about the seriousness with which this situation was being approached by the Scottish Government.

Contact with Board of NHSGGC Prior to Escalation

24. As explained above, my role as DGHSC incorporated holding the position of Chief Executive of the NHS in Scotland. It is important to understand that this does not mean that I had any line-management responsibility for anyone

within NHSGGC. The Health Board's Chief Executive reports to the Chair and to the Health Board. The Chair of the Health Board is answerable to the Cabinet Secretary, not the DGHSC. When I took up post, I visited Health Boards and made a point of meeting with their Senior Leadership Teams ("SLT"). This included NHSGGC. I had monthly group meetings with NHS Chief Executives, but not individual one-to-one meetings. That is in keeping with the role and remit of the DGHSC, as explained above and in my pervious witness statement. My main contact with NHS Board Chief Executives was through the cycle of annual reviews, mid-year reviews, monthly business meetings and familiarisation and engagement visits to NHS Boards and Integration Joint Boards, which were focussed on the Cabinet Secretary's strategic priorities. I met the leaders of the Chief Executive's Group regularly to discuss strategic issues from both a government and a service perspective.

Support and Resources Available to NHSGGC during Stage 4 Escalation

25. I am asked what support and resources were provided to NHSGGC to assist them in "recovering from" being escalated to Stage 4 of the Escalation [Support and Intervention] Framework. As the Inquiry has heard at previous hearings, the NHS Scotland Support and Intervention Framework is one of the key elements of an evidence-based approach to monitoring performance and managing risk across the NHS in Scotland. The Framework operates to ensure that appropriate levels of support are provided to Health Boards at any given time. The framework applies to the 14 NHS territorial boards only. The nature of support and intervention by the Scottish Government will vary, depending upon the issues presenting, with Health Boards moving up and down levels on the Framework based upon advice received from HSCMB. Health Boards could be escalated for Health Board-wide challenges or specific issues. The Framework is overseen by the National Planning and Performance Oversight Group ("NPPOG"), a sub-group of HSCMB, which was chaired by John Connaghan and had a membership including representatives from all of the Health Directorates within the Scottish Government. The NPPOG provided a summative view of all of the concerns about NHSGGC.

26. The Scottish Government provided a range of interventions and supports to NHSGGC when it was escalated to Stage 4 in order to address the various interconnected issues that were being identified. By way of reminder, the statutory responsibility for the delivery of healthcare remained with NHSGGC during Stage 4 escalation, with the Chief Executive of NHSGGC remaining the Accountable Officer. The Framework provides that at Stage 4, the support and intervention provided by the Scottish Government will include senior level external support reporting to an Assurance Board chaired by the Scottish Government, which will report direct to the DGHSC. The onus remains on the NHS board to deliver the required improvements. The primary vehicle for provision of the intervention and support required was, therefore, the OB.

27. As was set out within its Terms of Reference, the purpose of the OB was to support NHSGGC in determining what steps were necessary to ensure the delivery of and increase public confidence in safe, accessible, high-quality, person-centred care at the QEUH/RHC and to advise the DGHSC that such steps had been taken. In particular, the OB was tasked with seeking to:

- ensure appropriate governance is in place in relation to infection prevention, management and control;
- strengthen practice to mitigate avoidable harms, particularly with respect to infection prevention, management and control;
- improve how families with children being cared for or monitored by the haemato-oncology service have received relevant information and been engaged with;
- confirm that relevant environments at the QEUH and RHC are and continue to be safe;
- oversee and consider recommendations for action further to the review of relevant cases, including cases of infection;
- provide oversight on connected issues that emerge;
- consider the lessons learned that could be shared across NHS Scotland; and
- provide advice to the DGHSC about potential de-escalation of the NHS GC Board from Stage 4.

28. As Chair of the OB, the CNO will be able to speak to the considerable work carried out by the OB and its various sub-committees. A significant input of expertise is provided to a Health Board when they are escalated to Stage 4 of the Escalation Framework. In my view, key elements of the intervention and support provided through the vehicle of the OB were by virtue of the various appointments of the CNO, Professor Craig White, Professor Marion Bain and Professor Angela Wallace, together with the steps taken in mobilising HPS and HFS to be in and around the very complex scientific questions that were being addressed about infection prevention and control.

Consideration of Escalation of NHSGGC to Stage 5 of the Escalation Framework

29. I am asked whether consideration was given to escalating NHSGGC to Stage 5 of the Escalation Framework. An escalation to Stage 5 involves the use of the Cabinet Secretary's statutory powers of intervention and is, therefore, a decision that rests with the Cabinet Secretary as a Scottish Minister rather than the DGHSC. Stage 5 escalation would only be used in the most exceptional circumstances when the Scottish Ministers are of the view that a Health Board as a whole requires direct statutory intervention because of the view that the Board are unable to deliver safe and effective healthcare ("The level of risk and organisational dysfunction is so significant that the NHS Board requires direct intervention using statutory powers of direction"). This is a drastic measure, which includes a judgement being reached that the Health Board is unable to deliver safe and effective care without direct intervention. I have not personally been involved in a Stage 5 escalation during my time in Scottish Government. As far as I am aware, there has only ever been one escalation to Stage 5, which was in 2018, when NHS Tayside was escalated following serious concerns about governance, financial management and the use of charitable funds for operational expenses.

30. While any decision to escalate NHSGGC to Stage 5 would have been one for the Cabinet Secretary, I carefully considered all options and the necessity of each stage of intervention. As I have set out, my decision to escalate to Stage 4 was informed by the recommendation of the HSCMB. My sense on the necessity for escalation was linked to the question of infection prevention and control at the QEUH/RHC rather than the entirety of the running of NHSGGC. Escalating NHSGGC to Stage 5 on the Framework would have involved a huge diffusion of effort and responsibility in the Scottish Government taking over the whole of NHSGGC, which I considered not to be appropriate or proportionate given my view that there was a need to focus on the immediate and critically important infection prevention and control at the QEUH/RHC. I believe that an escalation to Stage 4 allowed the Scottish Government to put in place oversight and support that was focused and targeted at the IPC concerns in hand, and that escalation to Stage 5, with the much wider implications that would have involved, would have detracted from this very important work (noting that NHSGGC has a huge estate across which it delivers a wide range of services) .

De-Escalation of NHSGGC from Stage 4 to Stage 2 of the Escalation Framework

31. I am asked about my understanding of the changes that the Scottish Government would have expected from NHSGGC in order to be de-escalated from Stage 4 of the Escalation Framework. I understand that NHSGGC was de-escalated from Stage 4 to Stage 2 of the Framework in June 2022. As I have previously explained, I retired from my role as DG on 31 July 2020, following a period of sick leave that had run from 22 April 2020. I was, therefore, not in post at the time that the decision was made to de-escalate NHSGGC, so I cannot comment upon this.

Terms of Reference and Flow of Information from the OB

32. As previously referred to, the remit of the OB is set out in its Terms of Reference ("TOR"), from which I have quoted above **(Bundle 52, Volume 1, Document 4, Page 24)**. My recollection is that the TOR were developed by the CNO and reviewed and approved by myself and the Cabinet Secretary. I was content with the scope of the TOR and signed these off with my full support, alongside the Cabinet Secretary.

33. I am asked what my role was in ensuring that the TOR of the OB were fulfilled. I lined-managed the CNO and received regular written and verbal updates about the work of the OB. I was also copied into written briefings to the Cabinet Secretary. As set out within my previous witness statement to this Inquiry, the Cabinet Secretary met with all Scottish Government Directors working on her portfolio on a weekly basis. The Cabinet Secretary, therefore had and took regular opportunity to discuss the work of the OB. I recall the Cabinet Secretary reading all updates carefully and asking questions in light of what she had read as a matter of course. I recall there being a constant flow of information to the Cabinet Secretary from the OB through its minutes and papers.

34. I am asked to explain how the OB's role differed from other governance and performance management structures within NHSGGC. A unique aspect of the OB's structure is that it included the attendance of senior staff from NHSGGC and linked closely with NHSGGC management committees, but it was fundamentally different from NHSGGC's own internal governance structures because it reported directly to the Scottish Government rather than the Board of NHSGGC and was led and driven by the Scottish Government.

35. I am asked to what extent the OB was responsible for the operations of NHSGGC. I am unclear what the Inquiry means by "*operations*", but ultimately, in the absence of Stage 5 escalation, the responsibility for the day to day running of a Health Board in Scotland remains the responsibility of that Health Board and its Accountable Officer. There was a uniqueness with the

OB in that it had authority from the Scottish Government to direct certain work that fell within its TOR, and to understand and make improvements in the operation of infection, prevention and control within NHSGGC.

36. The OB was not independent of Scottish Government. It was established by and accountable to the Scottish Government. The OB acted under the authority of the Cabinet Secretary and the DGHSC of the Scottish Government, so it was inherently independent of NHSGGC.

37. I have been asked whether I had the authority to direct the OB and, by extension, NHSGGC to act in a particular manner. I would have the authority to do so in exceptional circumstances if I believed that the OB was not operating within its TOR, but such an issue did not arise as I had full confidence in the work that the CNO and the OB were taking forward. If such a situation did arise, I would only exercise this authority with the agreement of the Cabinet Secretary.

Interim and Final Reports of the Oversight Board

38. I have been asked to provide my views on the local recommendations within the Interim and Final Report of the OB and comment on any specific challenges and successes in implementing their recommendations **(Bundle 6, Document 35 and 36, Pages 700-921)**. I was retired by the time both of these reports were published, so have no comments on their content or the implementation of any recommendations contained within them.

Water and Ventilation System at the QEUH

39. I am unable to assist the Inquiry in relation to its question about what steps the Scottish Government took during the Stage 4 escalation to ensure that the water and ventilation systems in the QEUH were in compliance with the relevant statutory regulation and other applicable recommendations,

guidance, and good practice. I believe that this is a query that Alan Morrison, who is still within the Scottish Government, may be able to answer.

40. Similarly, I am unable to assist the Inquiry in relation to its query about what steps the Scottish Government took during Stage 4 escalation to ensure that the operation of IPCT within the QEUH and RHC was being carried out in compliance with the National Infection Prevention and Control Manual, and to the satisfaction of me, Health Protection Scotland and ARHAI. This is a matter of the expertise for the CNO, and the work of the OB, so I would defer to Professor McQueen on this point. One of the sub-groups of the OB was focused upon the system of IPC within NHSGGC. Again, this would fall within the expertise of the CNO, so I would defer to Professor McQueen on this point.

41. I have been asked "whether the Scottish Government were aware that the PPVL isolation rooms at the QEUH/RHC were not suitable for immunocompromised patients in December 2019". I do not know the answer to this question and would suggest that Alan Morrison may be better placed than I am to assist with this sort of question.

42. I am unable to assist with the Inquiry's queries about "the Scottish Government's knowledge in December 2019 of the validation of the ventilation systems or the air change rates in general wards at the QEUH/RHC". I believe that the former CNO and/ or Alan Morrison may be able to assist with this query.

43. I am asked comment upon "the Scottish Government's knowledge regarding whether risk assessments had been completed for the general wards in the QEUH/RHC in December 2019". I am unable to provide any assistance on this matter and, again, would suggest that Alan Morrison may be better placed than I am to assist with this sort of question.

44. I am also unable to comment upon "the extent of the Scottish Government's knowledge in December 2019 as to whether the ventilation system in ward 4C

met the air change rate, pressure differentials and requirement for HEPA filtration set out for a 'Neutropenic Ward' in SHTM 03-01".

Communication and Engagement – Recommendations of the Interim and Final Report of the OB

45. As I have set out, I was retired by the time the recommendations of the OB's Interim and Final Report were released. By reference to the paper prepared by HSCMB, communication and engagement with patients and families was one of the key considerations for escalating NHSGGC to Stage 4 of the Escalation Framework. As I have set out, significant concerns were being raised by clinicians, patients, families and their elected representatives in the Scottish Parliament about the communication and engagement from NHSGGC and this was high on the Cabinet Secretary's list of priorities. This is highlighted, in part, by the appointment of Professor Craig White prior to NHSGGC being escalated to Stage 4.

46. I am unable to assist the Inquiry with its query about the steps taken by NHSGGC to implement the local recommendations of the OB and the effectiveness of those steps, given that I was retired from post by this point.

Independent Review

47. An Independent Review was announced in the Scottish Parliament, by the Cabinet Secretary on 22 January 2019, to review the QEUH/RHC design, commissioning of work and the construction, handover and maintenance of the building to identify where issues were raised that should have been addressed and identify lessons to be learned for the NHS in Scotland **(Bundle 27, Volume 9, Document 11, Page 145 and Bundle 52, Volume 1, Document 27, Page 328 and Bundle 52, Volume 1, Document 28, Page 335).** This was prior to my having taken up the post of DGHSC. The Independent Review Report was published on 15 June 2020 (at which point I

was absent from work due to sickness, leading to my retirement). I am, therefore, not well-placed to answer questions in relation to either the commissioning of or report produced by the Independent Review.

48. I am aware that the Independent Review made a series of findings and recommendations. I do not consider myself to be in a position to dispute or pass judgement on those findings. I am unable to answer whether the Independent Review adequately dealt with the concerns arising from QEUH for the same reasons that I have provided above.

49. The Inquiry has asked whether I gave consideration to establishing an independent review under powers in section 76 and schedule 12 of the National Health Service (Scotland) Act 1978 ("the 1978 Act"). The Independent Review was established prior to my taking up the post of DGHSC, so I am unable to comment on what consideration or advice was given to Ministers about alternative forms of review.

50. I am unable to assist the Inquiry with its query as to ongoing monitoring or follow-up review to assess whether the changes recommended in the Independent Review are being sustained over time (again due to no longer being in post).

Case Note Review

51. I am aware that the Case Note Review ("CNR") was established by, and reported to, the OB on 28 January 2020 and, while I did not have a direct role in initiating or supporting this process, I was kept fully informed and supported the establishment of the CNR. I recall work going on to set up the CNR; and my recollection is that the CMO and CNO were heavily involved in this work.

52. I considered the CNR to be a necessary piece of work to address the concerns raised by staff, patients and external bodies at the QEUH/RHC and

was supportive of it. It seemed a very reasonable step to pull together a multidisciplinary team to examine the circumstances of individual patients.

53. I am asked to indicate the extent to which I would *"accept that the decision of the CNR to ensure that individual reports that informed the findings of the CNR remained confidential has allowed NHSGGC to reject the conclusion of the CNR and attempt to persuade the Inquiry and patients and families that there is no link between all but two of the infections in the Schiehallion patient cohort and the hospital environment"*. The CNR published its findings in March 2021, after I had retired from post. I understand, at a high level, that the team working on the CNR were working within the Caldicott Principles about patient data and offered individual feedback to individual families. I am not qualified to share a view on decisions taken by the healthcare professionals in the CNR; and am unable to substantively comment on matters that occurred when I was no longer in post. I believe that the CMO and CNO may be best placed to answer any queries that the Inquiry may have about this.

54. For reasons that I have provided above, I am also unable to assist the Inquiry with its query about whether I would accept *"the criticism that the structure of the CNR has had the effect of resulting in a situation where around 30% of the patients who received a report from the CNR indicating that a link between their infection and the hospital environment was "probable" might well have anticipated receiving an appropriate duty of candour acknowledgement from NHSGGC for that connection, but now have not done so as a consequence of the position of NHSGGC"*.

NHS Scotland Assure

55. I am asked what key factors and events at the QEUH/RHC led to the establishment of NHS Scotland Assure ("NHSSA"). As I have set out in my earlier statement for the Edinburgh IV hearings, the concerns that arose at the QEUH/RHC, as well as the RHCYP/DCN, very much influenced the

establishment of NHSSA. These new build projects highlighted the importance of having a centralised point of expertise and an independent assurance process in ensuring that new build projects are meeting the relevant standards and guidance at each stage of the project.

Communication with NHSGGC

56. The Inquiry has referred to oral evidence that I gave during the Edinburgh IV hearing and a comment that I would meet with Chief Executives of all NHS Boards on a monthly basis. I would clarify that my evidence in this respect was in reference to the Chief Executives Business Meeting, held on a monthly basis, that I would chair and which would be attended by the Chief Executive of all Health Boards, together with a number of senior professionals from Health Boards, representing the HR Directors, Medical Directors, Nursing Directors and as well as all Directors within the Scottish Government Health and Social Care Directorate. The meetings generally covered strategic and performance issues relevant to the whole of the NHS in Scotland. These meetings would have an agenda and minutes would be taken. The Cabinet Secretary would also attend these meetings periodically to speak with Chief Executives about key strategic issues.

57. I visited Health Boards in Scotland when I was in post as DGHSC but I did not have regular one-to-one meetings with Chief Executives of the 22 Health Boards as there is no direct line of management between the DGHSC and Chief Executives of Health Boards.

58. It is very important that proper lines of accountability and communication are maintained within Government, particularly when liaising with external bodies such as Health Boards. As I have set out in paragraph 4 of this statement, the Chief Executive of a Health Board is accountable to the Chair of the Health Board. In turn, the Chair is accountable to Scottish Ministers. As DGHSC and Chief Executive of the NHS in Scotland, I would not have direct or specific communication with the Chief Executive of an individual Health Board unless

it was on behalf of the Cabinet Secretary or at the request of one of the DGHSC directors on a very specific issue. I do not recall being asked to have any communication directly with Jane Grant other than as set out at paragraph 20, above. Had I been so requested, I would only have communicated on the express terms set out by the Cabinet Secretary, so as to ensure clear and consistent messaging in line with the Cabinet Secretary's approach.

59. I have been asked how Jane Grant, Chief Executive of NHSGGC, and I structured our monthly meetings to address the operational and clinical concerns at the QEUH/RHC. As I have explained, this would be to misunderstand both the respective roles and responsibilities of the DGHSC, Health Boards and Health Board Chief Executives and Chairs that I have set out at paragraph 4 of this statement and the nature of the monthly meetings, which I have explained at paragraph 24, above, were not one-to-one meetings with individual Chief Executives. I met Jane Grant (as well as the Dean of the Medical School and others) during my initial visit to NHSGGC after I commenced my post, but this was not a formal meeting.

60. Directors within the Scottish Government would have regular conversations with Chief Executives and other senior professionals from Health Boards on their policy lead areas. To that end, Jane Grant would have been in communication with the CNO, who was the Policy Lead for HAI, and other Directors on other issues such as Board performance against key objectives.

Capital Investment Group

61. I am asked what my role was in guiding the Capital Investment Group ("CIG") in addressing the capital and infrastructure challenges at the QEUH. I did not have a direct role in the CIG. This instead came under the remit of Christine McLaughlin as the responsible Scottish Government Director. Mike Baxter and Alan Morrison have both previously given detailed evidence to the Inquiry on the remit, role and operation of the CIG.

62. The DGHSC has a remit to make key decisions about funding or resource allocation only within set financial parameters. During my tenure, the funding limits delegated to health boards for capital investment projects were set out within CEL 32 (2010) **(Bundle 4, Document 11, Page 146)** which were then updated when Christine McLaughlin, Chief Finance Officer NHS Scotland and Director of Health Finance, Corporate Governance and Value, issued DL(2019)05 on 12 September 2019. Only capital investment projects that exceeded health board delegated limits would come to me for approval following consideration and recommendation for approval from the CIG. During my time in post, capital investment projects that came to me from the CIG included NHS Highland's Redesign of services for Skye and Badenoch and the Golden Jubilee Foundation Hospital Expansion Programme Phase 2.

63. I am asked what steps the CIG took to ensure that both immediate and long-term solutions were implemented at QEUH and how I prioritised the most urgent needs. As I did not have a direct role in decisions about funding or resource allocation within the CIG, I cannot assist the Inquiry with their queries.

Miscellaneous

64. I am asked by the Inquiry, in a Rule 9 supplementary question, whether it might assist a future Cabinet Secretary if legislation gave Scottish Ministers powers to remove only the executive board members of a Health Board and leave the non-executive board members in place. I do not, personally, think that this would help a future Cabinet Secretary, however that would be a position for a future Cabinet Secretary to determine. I am sure the Inquiry already understands this, but to be clear: the Cabinet Secretary holds the chair to account; the chairs and non-executives hold the executives, including the chief executive, to account; the executives are employees of the board, not the Scottish Government. The chair directly holds the chief executive to account and has close day-to-day contact and performance management

responsibilities with and for the chief executive. In line with current primary legislation, health boards are statutory bodies and directly employ their staff.

65. I am also asked by the Inquiry whether there is *"any risk that the fact that under Stage 4 responsibility for the day to day running of a health board remains the responsibility of that Health Board and its Accountable Officer means that issues of institutional culture that may be connected to the underlying reason for the escalation cannot be addressed without full co-operation of that Health Board and its senior officers"*. I am not sure that one can entirely mitigate against such risk, but I expand below upon how such risk is managed. The issue of institutional culture would be a wider issue across the Health Board and a Stage 4 intervention would give important external insights as to the level of impact of institutional culture on the issue of infection prevention control and would be an indicator of wider issues within the Board. NHS Highland was an example of such an approach during my time as DGHSC. That was managed through escalation to Stage 4 on the Framework in November 2018, with cultural issues in particular being addressed through the Sturrock Review (published in May 2019) and subsequent work to implement its recommendations.

66. I am also asked in a Rule 9 supplementary question, whether the only means by which the Scottish Government could direct the NHSGCC to act in a particular manner would be for the Cabinet Secretary to escalate the board to Stage 5. The Cabinet Secretary already has significant powers of direction. Any Cabinet Secretary would need to be confident that a specific direction on a specific issue would achieve the desired outcome and could not be achieved through alternative interventions.

67. These questions are all connected and it might assist the Inquiry if I add to my specific answers, above, the following more general observations.

68. The Cabinet Secretary, working through the Board Chair, requires the full co-operation of the health board and its senior officers. If that full co-operation is not forthcoming, then the Cabinet Secretary will hold the Chair to account.

The Chair, together with the non-executive Directors, through the Board's employment and performance management responsibilities, will hold the Chief Executive and the Executives to account. As mentioned before, during my time in office, the Cabinet Secretary met with all of the health board Chairs once a month, had regular, individual conversations with individual Chairs on a range of topics pertaining to issues at individual Boards. This was supplemented by the process of annual and mid-year performance reviews of the Board, through which the Cabinet Secretary, with a DGHSC and DGHSC directors in attendance as required, would hold the Chairs and their Chief Executives to account. Effective management of the risk that presented in relation to the situation at the QEUH/RHC required consideration to be given not only to mitigations that could be brought to bear in the form of Stage 4 interventions, but also further risks that could present through escalation to Stage 5.

69. Escalation to Stage 5 would have involved the Scottish Government taking over the running of all aspects of the services run by NHSGGC, not only the QEUH/RCH. It should be borne in mind that escalations are often made for specific issues within boards rather than having the whole board at a particular level. Escalation to Stage 4 enables the appointment of a transformation team led by a Scottish Government director, in this case the Chief Nursing Officer who is the policy lead for IPC in the Scottish Government. The transformation team was populated by Senior professionals and a family representative. It is noteworthy that the NHSGGC senior staff were observers only. Escalation to Stage 4 in this case was for specific issues relating to IPC at an individual hospital. That escalation did not preclude the Cabinet Secretary from taking further action, including escalation to Stage 5 or removal of the board chair if she considered that functions were not being properly fulfilled on behalf of the Cabinet Secretary, as had happened before in relation to at least one Health Board. In this instance, the recommendation was specifically related to IPC and not wider performance of the board. In particular, it was related to the effectiveness of the IMT and related governance at the QEUH/RHC; to enable specific support on IPC, communications and engagement in relation to the QEUH/RHC; and the

central concern was a lack of information sharing, transparency, communications amongst members of the IMT clinicians and families.

70. As I mentioned previously, concerns had been heightened as a result of the issues raised by families on 28 September and 1 October, the meeting chaired by the CNO on 25 September, the information shared by the whistleblower on the 14 October and issues that came to light following the appointment of Craig White. The escalation recommendation paper confirmed that there was no evidence to suggest systemic issues that would require whole system intervention.

71. The way matters operate in practice may, perhaps, be best demonstrated by example. A Cabinet Secretary sets a policy on, for example, breastfeeding. She can and does, through her senior civil servants, require a health board (usually in such strategic directions all health boards) to take action to implement those policies. The Cabinet Secretary sets overarching strategic direction for health boards. It is not the role or function of the Cabinet Secretary to manage the detail of how individual health boards implement the policy direction set by the Scottish Government, operating through the Cabinet Secretary as the responsible Scottish Minister. Operational level decision making on how to effectively implement health policy is delegated to health boards. Mechanisms are in place through a variety of agencies (co-ordinated through NHSNSS - whether, for example, HPS, HFS, HIS or now NHSS Assure) to provide assurance to the Scottish Ministers as to the safe and effective delivery of the health service in Scotland. It is only in the most exceptional circumstances that the Scottish Ministers would take steps that would supersede the functions delegated to health boards – those being an emergency powers situation (as best illustrated during the Covid-19 pandemic, when powers under s.78 of the National Health Service (Scotland) Act 1978 were invoked), or in a situation where a health board was escalated to Stage 5, meaning that the functions delegated to the health board would be taken back by the Scottish Ministers and the Scottish Ministers would require to fulfil them directly.

72. With the caveat that I am not a lawyer and would readily defer to the Inquiry Chair on any matters of statutory interpretation, in terms of the legal framework I understand that the Cabinet Secretary for Health and Social Care exercises legal powers over NHS Health Boards primarily through provisions in the National Health Service (Scotland) Act 1978, most commonly:

- Section 2(1) – General Duty of Scottish Ministers, which establishes the duty of the Scottish Ministers to promote a comprehensive health service and provides the foundation for ministerial oversight of NHS Scotland.

- Section 2(5) – Power to Give Directions, which empowers the Scottish Ministers to give directions to Health Boards regarding the exercise of their functions and is one of the most frequently used powers for intervention, including performance management and service delivery.

- Section 10 – Constitution of Health Boards, which allows the Scottish Ministers to appoint and remove members of Health Boards, including Chairs and underpins the Cabinet Secretary's authority to restructure board leadership when necessary.

- Section 105(7) – Power to Make Regulations and Directions, which grants the Scottish Ministers the ability to issue legally binding regulations and directions to NHS bodies and is often used in conjunction with other sections to formalise interventions

Conclusions

73. Looking back, I sought to take all actions necessary during my period as DGHSC to support the Cabinet Secretary and CNO in addressing the concerns raised in respect of the QEUH/RHC.

74. As concerns were emerging from the QEUH/RHC, the Scottish Government was taking steps to deploy the most senior relevant expertise available to support the Health Board to develop its engagement and communication, to find the cause of the infections and establish whether they were linked to the built environment. In my view, the work of individuals such as the CNO and Professor White, strongly supported by others including the CMO and HPS, was exemplary.

Declaration

75. I believe that the facts stated in this witness statement are true to the best of my knowledge, information, and belief. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.

The witness was provided access to the following Scottish Hospital Inquiry documents for reference when they completed their questionnaire statement.

Appendix A

A43293438 - Bundle 6 – Miscellaneous Documents

A50125560 - Bundle 27, Volume 9 - Miscellaneous Documents

A51210554 – Bundle 49 - Oversight Board, Advice and Assurance Review Group (AARG) and Healthcare Improvement

A50967356 – Bundle 52, Volume 1 – Miscellaneous Documents

A34216901 – Bundle 52, Volume 1 – Miscellaneous Documents

The witness provided the following documents to the Scottish Hospitals Inquiry for reference when they completed their questionnaire statement.

Appendix B

A34264952 – Bundle 52, Volume 1 – Miscellaneous Documents

A44686002 – Bundle 52, Volume 1 – Miscellaneous Documents

A34249195 – Bundle 52, Volume 1 – Miscellaneous Documents

A53237521 – Bundle 52, Volume 1 – Miscellaneous Documents