Scottish Hospitals Inquiry
Witness Statement of
Professor John Brown CBE

1. This statement has been given in support of the Scottish Hospitals Inquiry. The issues addressed in this statement include those identified by the Inquiry as relevant to my former role as Chair of NHS Greater Glasgow and Clyde (NHSGGC) and my comments and insights include my response to specific questions set by the Inquiry team.

2. I have been unable to answer all of the questions sent by the Inquiry team as in some cases I do not possess the technical or clinical knowledge to give an informed view on the subject, or the matter being highlighted is outside of my role as the NHS Board Chair and was dealt with as an operational management issue by the Corporate Management Team.

3. Any deficiency in the technical and clinical knowledge of individual NHS Board Members is rectified by an integrated governance system that NHS Boards are required to have in place. The governance arrangements that provide the NHS Board with oversight of the service delivery are outlined in paragraphs 9 to 27 of this statement. These arrangements are expected to include providing Board members with information and assurance on the safety of the operating environment.

4. As some of the questions asked by the Inquiry team refer to a situation that existed from 2015, it has not always been possible to give exact dates when actions were taken but I have relied on my memory, or documents made available by NHSGGC or the Inquiry team to at least narrow the timeframe down to the year the issued occurred. I am assuming that where required, the Inquiry team will have details of the exact dates from the evidence of other participants.

5. When answering the Inquiry team's questions I have used 'NHSGGC' when referring the healthcare organisation and 'the NHS Board' when referring to the 30 Non-Executive, Executive, and Stakeholder members appointed by the Cabinet Secretary for Health & Sport to direct and oversee the governance of the organisation.

6. It should also be noted that the planning and design stage of the Queen Elizabeth Hospital (QEUH) and the Royal Hospital for Children (RHC) had been completed prior to my joining the Board of NHSGGC. The construction stage was completed, and the new hospitals were handed over by the construction company to NHSGGC shortly after I joined the NHS Board as a Non-Executive Member, eight months before I was appointed Board Chair.

7. Therefore, I was not involved in or had knowledge of the processes or governance involved in the planning and design of the new hospitals. I was not involved with the NHSGGC Project Team and had no part in the handover or commissioning of the hospitals. As a result, I am not able to comment on the extent to which the design or handover of the hospitals considered the specific requirements and risks to different cohorts of patients.

8. The previous NHS Board Chair, Andrew Robertson CBE would be best placed to answer questions on the planning, design, construction and handover of the hospitals, including the provision of appropriate ventilation and water supply to patients who are immune-supressed. Mr Robertson would also be able to provide details of the governance arrangements that the NHS Board put in place to oversee the planning design, construction and handover of the hospitals.

Personal Details and Professional Background

9. The CV included as Appendix B to this statement outlines my professional background, my current employment and the previous roles held by me since 2002. This includes a description of my role as Chair of NHS Greater Glasgow and Clyde.

NHSGGC Board and Governance

10. Descriptions of the role and responsibilities of NHS Boards and Standing Committees are included in the Scottish Government's policy document, the NHS Scotland Blueprint for Good Governance **(Bundle 52, Volume 1, Document 14, Page 194)**.

11. The Blueprint for Good Governance was commissioned by the Director General for Health and Social Care to support an independent governance review of NHS Highland. The review team developed the Blueprint to provide a baseline against which the governance of health boards could be assessed. The review team consisted of myself and Mrs Susan Walsh, a Non-Executive Member of the Healthcare Improvement Scotland Board. The development of the Blueprint reflected research into the best practice in both the private and public sector in the UK and abroad, interviews with a wide range of stakeholders, and the review team's personal experience of corporate governance in the public sector. This included my experience as a Director in the tax system, a company secretary in the education system, and a Chair in the National Health Service.

12. More detailed descriptions of the NHSGGC Board's governance arrangements and the guidance on implementing these arrangements are contained in a portfolio of documents that is developed, maintained, and communicated by the Board Secretary. This includes Standing Orders, Standing Financial Instructions, Schemes of Delegation, and Risk Management Instructions that provide the senior leadership and management of the NHS with their principal operating guidance. These documents are reviewed, revised as necessary, and approved by the NHS Board on an annual basis. Copies of the operating guidance documents are available from NHSGGC.

13. The NHS GGC Board and the Standing Committees request, receive and consider information from the Corporate Management Team and other sources in writing or verbally at meetings. This information supports effective decision making and constructive debate and provides assurance to Board Members on the delivery of the organisation's purpose, aims and objectives.

14. The corporate governance system is designed to ensure that decisions by Board members are well informed, evidence based, and risk assessed. This not only includes the efficiency and effectiveness of the services delivered to patients and service users but also the safety and quality of the healthcare provided by NHSGGC. This would include the identification, management, mitigation, and reporting of risks to patient safety from the hospital environment, including the water and ventilation systems.

15. The Scheme of Delegation and the Terms of Reference of the Standing Committees describe the decision making responsibilities within the NHSGGC governance system and from this it can be determined who would be required to confirm the need for and authorise works to improve or remedy deficiencies in the hospital environment, including the water and ventilation systems.

16. The NHS Board formally meets six times a year. The meetings are conducted in public, and Agendas, Minutes and Board Papers are available on the NHSGGC website. The NHS Board can also meet on an ad-hoc basis between the scheduled meetings, should the need arise to discuss any urgent issues before the next meeting.

17. Board members are also invited to seminars three times a year to receive training and information on any new initiatives or changes to legislation that affect the NHS. These informal meetings are not open to the public and the information received is usually in the form of PowerPoint presentations. This is not a decision-making forum and any actions proposed at these meetings would have to be approved at an NHS Board or Standing Committee meeting.

18. The Standing Committees either meet three or four times a year, on dates prior to the formal Board meetings. These meetings are held in private, but a report of the items discussed, and decisions made is presented at the public NHS Board meetings. This report and the Minutes of the meeting are included in the Board papers that are available on the NHSGGC website.

19. In addition to agreeing the information required for the standing agenda items, the standard assurance information pack, and the mandatory reports expected by the NHS Board, the Chief Executive, Board Chair and Vice Chair meet to agree what other issues or concerns should be escalated to the NHS Board. The same system is in place for the Standing Committees and at each of their meetings a decision is made on what needs to be escalated for decision or decisions at the next meeting of the NHS Board.

20. The Corporate Management Team are also required to identify any issues, decisions and reports that should be escalated to the NHS Board or the Standing Committees. These would then be discussed with the Chair and Vice Chair of the NHS Board, or the Standing Committee and a decision made to include the item on the agenda for the next meeting.

21. The concerns around the potential risks to patient safety from the hospital environment, including the water and ventilation systems, would have been included in the discussions the NHS Board and Committee Chairs/ Vice Chairs held with the Corporate Management Team concerning the information required by Board Members. This process was designed to provide assurance that all significant questions about the safety and quality of healthcare services were being addressed, and to ensure the monitoring, progress, and resolution of the management of issues and risks, including those identified in relation to the safety of the hospital environment.

22. Throughout my time as NHS Board Chair, the NHS Board adopted an active and collaborative approach to governance. This included adopting a continuous improvement approach to the corporate governance arrangements in NHSGGC. The changes in the governance structure introduced during my term as Board Chair, including the establishment of new committees and the

requirement for the Chairs of Standing Committees to update on discussions and decisions made at their respective committees reflect that approach being delivered. The Scottish Government and the NHS Board are satisfied that the implementation of this approach has enhanced and strengthened the governance of NHSGGC at Board level.

23. The NHS Board's role can be clearly differentiated from that of the Corporate Management Team. The Corporate Management Team is the principal decision-making body for operational management within NHSGGC. To support the effective management of operational issues, the Corporate Management Team have put in place a hierarchy of management teams and advisory groups across the organisation. These teams and groups meet formally and informally to deliver the services delegated to their sector or business unit of NHSGGC. These teams and groups form part of the decision-making framework that reports to the Corporate Management Team who hold them accountable for the delivery of services to patients and service users. This includes the identification, management, mitigation, and reporting of risks to patient safety from the hospital environment and compliance with the Scottish Government's guidance on infection prevention and control.

24. It is important to note that there is a separation of the corporate governance and operational management functions from the decisions made by clinicians on the care and treatment of patients. Therefore, both clinical decision-making and the medical treatment of specific patients do not fall within the ambit of the NHS Board, the Standing Committees, or the Corporate Management Team and its subordinate teams or groups.

25. The governance arrangements described in paragraphs 9 to 27 of this statement provide the NHS Board with the opportunity to scrutinize and challenge the outcomes of the decisions made by operational managers on the quality of care delivered by NHSGGC, including the impact of their decisions on patient safety.

26. Any concerns expressed by staff that there is evidence of wrongdoing, failures in performance or inadequacies of systems are investigated and reported in compliance with the Whistleblowing policy introduced by the Scottish Government to respond to this type of situation in the healthcare system. This policy requires that Board Members be aware of whistleblowers' concerns and the opportunity is provided for them to review and challenge the senior management team's response.

27. The specific concerns about the safety of the hospital environment raised by staff were taken very seriously by the NHS Board and were considered by Board Members in accordance with the NHSGGC policy on Whistleblowing. The application of the NHSGGC Whistleblowing policy in this instance was reviewed at senior management and at Non-Executive Board Member level and found to be compliant.

28. Following the appointment of Mr Charles Vincent as Whistleblowing Champion by the Cabinet Secretary, the NHS Board commissioned a review of the effectiveness of the NHSGGC Whistleblowing policy. The NHS Board was assured by the outcome of the review that the Whistleblowing policy remained fit for purpose. A copy of Mr Vincent's report is available from NHSGGC.

29. As the NHS Board Chair, I was in regular contact with both the Cabinet Secretary and the Director General for Health and Social Care concerning the safety of the hospital environment, including the concerns raised by whistleblowers around the water and ventilation systems. In addition to face-to-face meetings, these exchanges were by email, text, and phone calls. At these informal discussions, we not only discussed the possible cause of these concerns but also the actions being taken by NHSGGC to address these challenges and restore public confidence in the safety of the hospital environment. The Cabinet Secretary and the Director General also received regular and detailed briefings from the NHSGGC Chief Executive and the government officials who were advising and supporting the Corporate Management Team.

Handover

30. As I was a new Non-Executive Board Member and not personally involved in any aspect of the handover of the hospitals to NHSGGC, I do not consider myself well enough informed to comment on the extent to which the actions taken or not taken at that time may have affected the safety of the hospital environment, including the ventilation and water systems.

31. My role as NHS Board Chair from December 2015 included oversight of the steps being taken by the Corporate Management to resolve the concerns and issues around the hospital environment from that date and while this has given me some insight into some of actions taken before then, I suggest that the Inquiry team’s questions around what happened in February 2015 would be more appropriate to being answered by the previous NHS Board Chair.

32. Following the handover, the issues that the Corporate Management were investigating were primarily around infection prevention and control. The possible links between the environment and the quality of the construction of the new hospitals and the safety of the hospital environment were being actively considered. These issues were unresolved when the Chief Executive, Mr. Robert Calderwood retired, and Mrs. Jane Grant became Chief Executive on 1 April 2017.

33. Although unable to confirm an exact date when I first became aware of the concerns and issues around the hospital environment, it would have been in 2016. I was advised of the situation that was developing at the QEUH Campus during my regular informal discussions with the Chief Executive and then more formally through the governance arrangements that were in place to provide information and assurance on infection prevention and control in the healthcare system.

DMA Canyon Report

34. In 2018, Dr Jennifer Armstrong made Board members aware of a Legionella Risk Assessment Pre-Occupancy Report and a Pseudomonas Report on Water Delivery System that had been completed by DMA Canyon Water Treatment Ltd in 2015 and 2017.

35. These reports highlighted concerns around the management of risks to the quality of the water system at the hospitals and identified the actions required to address these risks. I had been advised by the Chief Executive of the existence of the DMA Canyon L8 Risk Assessments prior to the presentation made by Dr Armstrong to the NHS Board in 2018 and the Board Members had no reason to doubt that Dr Armstrong had provided all the relevant information concerning this issue. Copies of the reports and Dr Armstrong's presentation can be provided by NHSGGC.

36. The reviews commissioned by the Director of Estates and Facilities from Health Facilities Scotland and Health Protection Scotland in 2018 identified delays in bringing the DMA Canyon risk assessment reports and the failure to complete all actions required to mitigate them to the attention of the Corporate Management Team, the appropriate Standing Committees, and the NHS Board.

37. In 2018 Board Members were also advised that there was no record of a risk assessment of the water system having been undertaken by the construction company or the NHS Board's advisors prior to the handover and the opening of the hospitals in June 2015. Until that point, I was also unaware of the NHS GGC decisions taken following the meeting with HPS, HFS and others in 2014 concerning the use of Home Optitherm Taps and the actions required to manage the risk they presented to water safety.

38. Following the discovery of the 2015 and 2017 risk assessments, the appropriate Standing Committees and the NHS Board received assurances from the newly appointed Director of Estates and Facilities, Mr Thomas Steele, that a review of the governance processes within the Estates and Facilities Directorate had been undertaken and control mechanisms and processes had been refreshed

to ensure this did not happen again. Mr Steele also confirmed to the appropriate Standing Committee and the NHS Board that that all the technical actions from the 2015 and 2017 Legionella Risk Assessment Pre-Occupancy Report and Pseudomonas Report on Water Delivery System reports had now been delivered.

39. While the time it took for the DMA Canyon reports to be discovered was of concern to the Board members, Mr Steele was not working in NHSGGC prior to 2018 and therefore unable to provide the NHS Board with the reasons why the recommendations in the 2015 and 2017 risk assessment reports were not actioned, or why the failure to do so was not escalated to the Corporate Management Team.

40. The failure to escalate the issues raised in the DMA Canyon reports was referred to in a letter to Ms Monica Lennon MSP concerning the death of a patient in 2017. The response given to Ms Lennon reflected the information known to the NHS Board and the Chief Executive at that time but recognised that in respecting individual patient confidentiality, it was not possible to comment on the circumstances surrounding the death of the patient specifically referred to by Ms Lennon.

Beatson Adult BMT Unit and Ward 4B

41. The transfer of Bone Marrow Transplant patients from Ward 4B in the QEUH to the Beatson West of Scotland Cancer Centre was completed in July 2015. As this also predates my appointment as NHS Board Chair, I was not involved in the decision to return the Adult Bone Marrow Transplant Unit to its previous location.

42. Therefore, the previous NHS Board Chair, would be best placed to answer questions on the governance around the decision to relocate the Adult Bone Marrow Transplant Unit, including why the ventilation system of Ward 4B had not been completed to a specification that would have enabled the Adult BMT service to remain at the QEUH, and why that did not prompt a wider investigation into the ventilation of the whole hospital.

43. As far as the relocation of the Adult BMT Unit back to the QEUH is concerned, my recollection is that the Acute Services Committee received a detailed option appraisal and risk assessment from the Director responsible for this service. The option appraisal complied with the governance arrangements at that time with a range of options having been identified, considered, and assessed against a previously agreed criteria by a group consisting of senior clinicians, managers, and estates staff. Therefore, the recommendation to return to the QEUH was accepted.

Ventilation Concerns/ Review of Ventilation

44. I was first advised about concerns having been raised around the rate of air changes at the hospitals by the Chief Executive, Mr Robert Calderwood, in 2016 when I was briefed on the reasons why the Adult BMT Unit had been relocated back to the Beatson. Mr Calderwood also referred to the situation in other parts of the hospitals where the standards included in the NHS Scotland guidance on the air change rate were not being met.

45. The NHS Board was aware of this situation and was satisfied that any risks to patient safety had been identified and were being effectively managed. NHSGGC would be able to provide details of the specific actions taken to identify, mitigate and report any risks to patient safety from the risk management framework. This framework is an integrated system that provides details of risk at various operational and management levels across NHSGGC. It includes escalation routes that bring changes to the level of risk to the attention of the NHS Board and the Standing Committees.

46. The risk management framework is a key component of the governance system and plays an important part in resolving conflicting opinions and arriving at a consensus view by the various management groups and governance committees that are responsible for patient safety, including infection prevention and control.

47. A review of the ventilation at the hospitals was undertaken in 2018 by Mr Jim Leiper. I was not involved in the commissioning of this work and have no recollection of seeing this report or it being discussed by the NHS Board or a Standing Committee and therefore I cannot comment on any specific actions taken by NHSGGC because of Mr Leiper's report. NHSGGC would be able to provide details of who received Mr Leiper's report and what actions were taken as a result of his findings.

Ventilation of Ward 2A – The Schiehallion Unit

48. I first became aware of concerns around the effectiveness of the ventilation system in Ward 2A of the Royal Hospital for Children in 2016. This was initially reported to me by the Chief Executive, and we agreed updates on the situation would be provided to the NHS Board through the formal governance arrangements in place at that time.

49. The Board Members understanding at that time was that any risk to patient safety was being prioritised and managed in accordance with the NHS Scotland infection prevention and control process. Infection prevention and control is one of the NHS functions that is governed by policies and procedures set by NHS Scotland and scrutinised by Healthcare Improvement Scotland on an ongoing basis. Reports on the level of compliance with the policy and procedures for infection prevention and control were standing agenda items at meetings of the Clinical Governance Committee and the NHS Board. Details of these discussions would be recorded in the minutes of the meetings, and these are available from NHSGGC.

50. My recollection is that the standard of ventilation was only considered an issue for patients with compromised immune systems and not one that had to be addressed for all the hospital wards. Therefore, the focus remained on resolving the situation with Ward 2A in the RHC and Ward 4B in the QEUH.

51. My recollection is that the Board members were surprised and disappointed that this situation had arisen, and the ventilation system did not meet the standards required for air change rate, pressure differentials and HEPA filtration. As time progressed this reaction was one that became common as we were made aware of the other defects in the design and construction quality of the new hospitals.

52. The recognition that the design of the isolation rooms in Ward 2A were not built to SHTM 03-01 standard was also mentioned in a draft options appraisal document in respect of the Adult BMT unit in March 2017. I do not recollect the discussion at the Acute Services Committee including mention of Ward 2A but would assume that as the paper stated that the rooms have a positive pressure of 10 PA hepafiltration, have anterooms, and it had been agreed to upgrade four of these rooms to meet the full standards, then the Board Members would have been assured that appropriate measures were in place or being taken to mitigate the risk to patient safety.

Ventilation of Ward 4C

53. In 2019 the NHS Board was advised of the Health & Safety Executive's investigation into the ventilation within Ward 4C. Updates on this issue would have been given to the Standing Committees as part of the regular reports on the management of health and safety risks within NHSGGC.

54. As the NHS Board Chair, I did not have the necessary technical expertise to contribute to the development of the HAI-Scribe risk assessment, nor would I have been expected to be involved. Responsibility for the completion and oversight of this work rests within the Corporate Management Team. The same would apply to the completion of any SBAR document by the infection prevention and control team that was addressing this issue. Therefore, I did not receive copies of the HAI-Scribe assessment or Dr Inkster's SBAR document.

55. My recollection is that although Ward 4C was not classified as a 'Neutropenic Ward' and HEPA filtration was not a legal requirement, the decision was made to introduce this facility to further reduce risk. This approach, i.e. where all possible action was taken to reduce the level of risk to the lowest possible level, was common at that time and reflects the extremely low level of risk appetite applied to patient safety in the hospitals.

56. This extremely cautious approach report to risk management at NHS Board level reflected a situation where different clinical opinions were being given to the Board Members on the potential causes of infections in different cohorts of patients. This was a recurring feature of discussions on this issue and while some NHSGGC clinicians argued that the ventilation system was a possible source of infection, others including Dr Peter Hoffman (an external expert from Public Health England) held the view that the number of air changes is not relevant to infection prevention and control. Details of the meetings where these discussions took place, and any reports of Dr Hoffman's contribution to the debate, can be obtained from NHSGGC.

57. Therefore, in the absence of a consensus clinical view on the extent or existence of the risk, the NHS Board encouraged and supported the introduction of all reasonable measures to mitigate risk to patients at that time.

'Water Incident' and Events in 2018

58. In 2018 I was advised by the Chief Executive that concerns had arisen around infections in the Schiehallion Unit and the hypothesis being considered by the Infection Management Team was that the water system might be a contributing factor to the situation. The Board Members were also advised of the concerns and of the decision to close the Ward as a precaution until the Infection Management Team identified cause of the infections and an appropriate response had been determined by them.

59. While the Board Members did not receive (or expect to receive) the minutes of the Infection Management Team or the other management groups meetings concerning the concerns around water safety, we were briefed at the Standing Committees and the NHS Board meetings about the situation. This provided

assurance to Board Members that the actions taken by the Corporate Management Team were consistent to the NHS Board's risk appetite where patient safety was concerned. This included taking the significant step of relocating the patients to Ward 6A in the QEUH until it could be determined that patient safety was not being compromised by the water system in the Schiehallion Unit.

60. The NHS Board and the Standing Committees were provided regular updates on the situation concerning the actions being taken to ensure the safety of the water supply through the formal governance arrangements and at Board Development Sessions.

Ward 6A and Events in 2019

61. Following the decant of the Schiehallion Unit, I visited Ward 6A on several occasions and discussed the situation with parents, staff, and managers. The staff were concerned about the length of time they were required to remain in the QEUH and suggested some improvements to the ward environment. This included a playroom for patients and better facilities for families spending considerable time on the Ward. Following discussions with the Corporate Management Team these issues were resolved and at my next visit I received positive feedback on the improvements made.

62. Concerns were also raised with me about delays in communications and the way the situation was being described in the Scottish Parliament and the media. I made the Cabinet Secretary, the NHS Board, and the Director of Communications aware of these issues.

63. The Chief Executive advised me of Dr Inkster's resignation as Lead Infection Control Doctor in 2019. I was advised that she had resigned for personal reasons and the Medical Director was supporting Dr Inkster and addressing the issues raised by her in her resignation letter. Dr Inkster's letter has been copied to me by the Scottish Hospitals Inquiry and now that I am aware of the issues identified by Dr Inkster as the reason for her resignation, it is clear that "personal reasons" do not accurately describe the situation.

64. In 2019 I was also advised by the Chief Executive of the concerns expressed by Professor Gibson and her colleagues concerning the hospital environment. In a letter to the Chief Executive and the Medical Director, Dr Gibson requested a meeting to discuss the situation. I was advised that the Chief Operating Officer, the Deputy Medical Director and the Director of Women & Children Services would take this forward, meet with Professor Gibson and her colleagues and ensure that the clinicians at the Royal Hospital for Children were fully engaged with the actions being taken to provide a safe environment for the treatment of their patients.

65. Following discussions with Scottish Government in 2019, the Chief Executive advised the NHS Board that Professor Fiona McQueen had approved the reopening of Ward 6A to new patients. Board Members were also advised that the NHSGGC Infection Management Team agreed with this decision.

Cryptococcus

66. As I do not have the necessary clinical or technical expertise or knowledge, I am not qualified to comment on the situation where two patients who died after contracting Cryptococcus neoformans were accommodated in rooms without HEPA filtration, whilst unable to be prescribed prophylactic anti-fungal medication. In particular, I am not qualified to give an opinion on what part if any that played in them contracting the Cryptococcus infection.

67. The NHS Board and the Standing Committees relied on updates on the investigations into the care of patients with Cryptococcus neoformans through the existing arrangements for clinical governance. These arrangements provided Board Members with reports that summarised the discussions and findings of the various clinical and managerial groups responsible for the oversight and management of infection prevention and control, including the Infection Management Teams.

68. The NHS Board had no influence or input to the work of either the Cryptococcus Infection Management Team or the Cryptococcus Subgroup. This includes their decisions on which hypotheses should be investigated or reported. This is true of all Infection Management Teams within NHSGGC.

Communication with Parents

69. In 2019 I was advised by the NHS Board Vice Chair, Mr Ross Finnie, that he had been asked by a third party to speak to Professor John Cuddihy concerning his daughter's treatement at the RHC. Molly Cuddihy was a patient of the paediatric haemato-oncology unit. I agreed with Mr Finnie that I would contact Professor Cuddihy and determine what action should be taken by NHSGGC to address his concerns.

70. I contacted Professor Cuddihy by phone and he described his daughter's illness, her treatment and his concerns about the safety of the hospital environment. Professor Cuddihy was concerned that his daughter's health had been damaged and her recovery from cancer was significantly at risk due to a healthcare associated infection that he felt could have been avoided. I advised Professor Cuddihy I would look into his concerns and identify the best course of action.

71. Following discussions with the Chief Executive and Medical Director concerning Molly Cuddihy's clinical condition and treatment, it was decided to invite Professor Cuddihy to meet with the Medical Director and Chief Executive. Given the seriousness of the issues raised by Professor Cuddihy and my previous offer to meet with any patients or families with concerns about the safety of the paediatric haemato- oncology unit, I decided to attend the meeting.

72. At the meeting with Professor Cuddihy, we discussed in detail his daughter's treatment and his family's concerns around the investigation into another patient who had the same type of infection while in the paediatric haemato-oncology unit. Professor Cuddihy's view was that had the source of the earlier infection been identified and eradicated, Molly would not have been infected by this bacteria.

73. The Medical Director explained the Scottish Government's policy on the investigation of single cases of infection and the guidance on linking cases for the purposes of infection prevention and control. She also confirmed that the policy and guidance had been properly applied in Molly's case.

74. While Professor Cuddihy acknowledged the time given by the NHSGGC senior leadership to reviewing his daughter's case, he was not convinced that the Scottish Government's policy was an effective or acceptable approach to the management of healthcare acquired infections. He clearly felt that Molly had been let down by NHSGGC, and had suffered as a consequence of what he considers the mis-management of infection prevention and control at the hospitals.

75. My engagement with Professor Cuddihy was informed by the briefings I received from the Chief Executive and Medical Director and I shared all the information I had with him at that time. I advised the NHS Board of my interaction with Professor Cuddihy as part of the Chairman's report at the NHS Board meeting and updates on any actions arising from the investigation into his daughter's case would have been provided to Board Members as part of the ongoing reporting on the overall situation.

76. As far as the quality of the communication by the Royal Hospital for Children is concerned, I believe that NHSGGC could have done better, and I am confident that lessons have been learned that will improve engagement with the families of patients in the future.

77. The Communications Director and her team have a key role in ensuring that any concerns about the safety of the hospital environment are quickly and effectively shared with the patients and families affected, the NHS staff involved in their care, and the general population who use the hospitals. In most cases, the input of the NHSGGC Communications team has ensured that the right information was received by the right people at the right time, including media statements and regular updates to front-line managers and staff across the QEUH campus.

78. However, communications on the issues around the hospital environment could have been more effective on some occasions, particularly when the cause of infections was still being determined by the clinicians. As each case was individually investigated, the cause of infection and the time taken to establish this varied from patient to patient.

79. Some patients, their families and staff should have been more frequently contacted to reassure them that, although no new information was available on the concerns around the hospital environment, this risk was being actively managed and mitigated while the cause for the concern was being investigated by suitably qualified clinicians.

80. Media statements were also issued with as much information as was available at the time. These statements were by necessity brief but did include background notes for editors. The need to provide updates on the situation in a short format did prove challenging on occassions when describing a complex situation and chain of events. It is possible that could have resulted in misunderstanding of the situation or the sequence of events but this risk was managed by scrutiney of the output from the communications team by members of the Corporate Leadership Team and from October 2019 by the Scottish Government.

81. While the appointment of Professor Craig White as an advisor to NHSSGC in October 2019 assisted the Communications Director in improving communications with the patients and their families, some delays in communications being issued could have been avoided had the Cabinet Secretary not also insisted on Professor White or herself personally approving communications with the patients, their families and the media.

82. It was not always possible to receive approval from the Cabinet Secretary or Professor White in time to meet deadlines from the media for publication of the NHSGGC response to concerns around the safety of the hospital environment with the result that families would on occasion obtain information about the hospital in which their child was being treated from the media, prior to the Health Board being permitted to issue any communication to them directly.

83. The communications around the safety of the hospital environment were also affected by media reports that expressed the views of some clinicians and Members of the Scottish Parliament who were critical of how the situation was being managed and reported by NHSGGC. This situation was made worse by an unnaceptable and widely reported comment by the NHSGGC Communications Director that Professor Cuddihy "may have won the battle, but he won't win the war."

84. The lack of information, the manner of some communications, the delays in communicating, the criticism of the management response to the situation, the accusations of a "cover up" or a "criminal conspiracty" all contributed to a lack of trust in the communications from NHSGGC. In some cases, this caused family members to decline to meet with senior management and clinicians to discuss their concerns.

85. One of the steps taken by NHSGGC to overcome the lack of trust in the organisation was to publish a detailed response to a list of issues raised by the families of children in the Schiehallion Unit. I was not personally involved in writing this document, but I was asked by the Chief Executive to review it before it was issued and give an opinion on whether the language used would be easily understood by people from a wide range of backgrounds. I believe the document that was issued made a positive contribution to the situation.

86. The NHSGGC Communications & Engagement Strategy describes the other actions and initiatives that have been taken to improve how the organisation communicates both its stakeholders. This approach has been scrutinised and approved by the NHS Board who receive regular updates on the effectiveness of both external and internal communications. Copies of these reports are available from NHSGGC.

Whistleblowing / Reporting of Patient Safety Issues by Infection Control Doctors and Microbiologists

87. I was advised by the Chief Executive in 2015 that the leadership team at the QEUH were experiencing difficulties in integrating some of the clinical teams at consultant level. This was despite the involvement of clinicians in the design of the QEUH Campus and although it had gone well across the hospitals, it remained a problem in a few areas, including the Emergency Department and the Infection Prevention and Control Team. I was advised the Medical Director was addressing these issues and it was not until the Infection Control Doctors raised their concerns formally through the whistleblowing process that the Board became aware of the specific concerns they had raised around the hospital environment. At that time, the Medical Director confirmed that although senior infection control doctors and microbiologists had been part of the team of clinicians involved in designing the QEUH and RHC, the whistleblowers remained concerned regarding the specialised ventilated areas within QEUH and RHC and the impact on patient safety. The date when the whistleblowing process was initiated, and the detail of the investigation is available from NHSGGC.

88. The concerns expressed by the Whistleblowers that environmental factors may be responsible for healthcare associated infections were investigated and reported in compliance with the Whistleblowing policy introduced by the Scottish Government to respond to this type of situation in NHS Scotland. This policy requires that Board Members be aware of the staff's concerns and the opportunity is provided for them to review and challenge the senior management team's response.

89. To protect the confidentiality of those involved, other than those Non-Executive Board members directly involved in specific case reviews, Board members do not have sight of the detailed whistleblowing reports produced following the investigations. The NHS Board and Standing Committees receive a summary of the investigations, including progress reports on any recommendations from the investigations.

90. The ongoing concerns about the safety of the hospital environment that were raised by the Whistleblowers, including those raised by Dr Penelope Redding in 2017 were taken very seriously by the NHS Board and were considered by Board Members in accordance with the NHSGGC policy on Whistleblowing. The application of the NHSGGC Whistleblowing policy was reviewed at senior management and at Non-Executive Board Member level and found to be compliant. Therefore, I had no reason to doubt the outcome of the investigation or to personally access any of the papers concerning the investigation.

91. The implementation of any recommendations from the Whistleblowing investigation and reviews were the responsibility of the Corporate management Team and progress against timescales was reported through the clinical governance arrangements in place at the time, including reference to the relevant Standing Committees and the NHS Board.

92. Updates on the implemention of the action plan that was introduced to address the issues raised by the whistleblowing investigation was provided to the Clinical and Care Governance Committee by the Infection Prevention and Control Team. The NHS Board would have received details of this work as part of the feedback from the Standing Committtes that the NHS Board receive at their meetings. This provided the opportunity to escalate any concerns to the full Board.

93. The Medical Director was responsible for ensuring feedback on the outcomes of the Whistleblowing investigation was provided to the Whistleblowers. Other than the exchange of emails with Dr Redding in 2022 where I shared my opinion on the NHS Board's confidence in the assurances received from the Corporate Management Team concerning the effectiveness of the infection prevention and control systems at NHSGGC, I have had no contact with the Whistleblowers. I have no recolection of receiving a letter or email from Dr Redding concerning her disatisfaction with the outcome of her Stage Three whistleblow and have been unable to find her correspondence or a reply. The Inquiry team may wish to ask NHSGGC to examine the files held by them and confirm the position.

94. Following the appointment of Mr Charles Vincent as Whistleblowing Champion by the Cabinet Secretary, the NHS Board commissioned a review of the effectiveness of the NHSGGC Whistleblowing policy. This review was led by Mr Vincent with support from an independent subject matter expert. A copy of this report is available from NHSGGC.

95. The NHS Board was assured by the outcome of Mr Vincent's review that the Whistleblowing policy remained fit for purpose. It should be noted that Mr Vincent is the son of one of the Whistleblowers and the Cabinet Secretary considered this to have added credibility to Mr Vincent's report.

96. The Whistleblowing policy and procedures were regularly reviewed and widely promoted throughout NHSGGC during my period as NHS Board Chair. This included discussions at the Area Clinical Forum and team meetings across the organisation. Articles on the role and importance of Whistleblowing were included in the Core Brief issued to all staff. Details of how to engage with the Whistleblowing process is also included on the NHSGGC website. I believe that it would be incorrect to suggest that Whistleblowing was not encouraged or supported in NHSGGC and have seen no evidence to support that suggestion.

Duty of Candour Policy

97. The NHSGGC Duty of Candour policy was approved by the Board in April 2018 and the Clinical & Care Governance Committee were assured in December 2018 that the policy had been effectively implemented. In 2020 the internal auditors provided further assurance to the Audit & Risk Committee that policies and procedures had been developed and implemented to fulfil the Board's obligations under the applicable legislation and regulations.

98. The NHS Board approved the Duty of Candour Policy (2018-2021). In December 2018, an update was provided to the CCGC who noted "In summary, the committee was content to note the report and update on the implementation of the Duty of Candour Policy. The Committee noted and were satisfied that this was being managed in line with policy requirements."

99. While the independent review undertaken by Dr Fraser and Dr Montgomery describes the NHSGGC Duty of Candour policy as adequate, they also advised that the Scottish Government should undertake further work on this matter.

100. My understanding is that Professor Craig White was asked to take this forward by the Scottish Government in 2020 and his work identified the need to provide further guidance to NHS Scotland on the definitions in the legislation, including what constitutes an incident and the meaning of unintended and unexpected in relation to healthcare incidents. This lack of consistency in the interpretation of the legislation by the health boards across Scotland lies at the root of the disagreement between Professor White and NHSGGC on whether the NHSGGC policy fully reflected the statutory requirements. The Duty of Candour policy was reviewed, updated, and approved by the NHS Board in 2021.

101. As the sponsor of the NHS Boards, the Director General for Health and Social Care has put in place a performance management framework to assist the Scottish Government in ensuring that NHS Scotland are delivering services and targets to the required standards, within budgets and with the appropriate governance.

102. The NHS Scotland Performance Management Framework provides five stages of a Ladder of Escalation that provides a model for intervention by the Scottish Government when there are concerns about a health board's ability to deliver the expected standards, targets, and governance. The model not only describes the stages of performance but also the level of support that would be provided by the Scottish Government at each stage.

103. In November 2019, the Director General for Health and Social Care escalated NHSGGC to Stage Four of the Performance Management Framework in relation to the systems, processes and governance surrounding infection prevention, management and control at the Queen Elizabeth University Hospital and the Royal Hospital for Children and the associated communication and engagement issues.

104. The intention of the escalation to Stage Four was to ensure appropriate governance was in place to increase public confidence and strengthen current approaches that were in place to mitigate avoidable harms.

105. The NHS Board was advised of the Director General's decision to escalate NHSGGC to Stage Four and the appointment of a Transformation team to support the organisation in resolving the issues identified by the Scottish Government Directorates for Health and Social Care.

106. At the same time, the Director General asked Professor Marion Bain, the former Medical Director of NHS National Services Scotland, to take over responsibility for infection prevention and control within NHS Greater Glasgow and Clyde. Professor Angela Wallace, the Executive Director of Nursing at NHS Forth Valley, was given this role in 2020, when Professor Bain was appointed to a different role in the Scottish Government. This decision meant that the Scottish Government were directly responsible for the management of infection prevention and control in NHSGGC and accountable to the Cabinet Secretary for Health and Social Care through the Oversight Board. This arrangement remained in place until 2022, when the Director General made the decision to return NHSGGC to Stage Two of the Performance Management Framework.

107. The Performance Management Framework has been used on several occasions across NHS Scotland in recent years and, in addition to NHSGGC, I have personal experience of its use in three other three health boards, NHS24, NHS Tayside and NHS Forth Valley.

108. My first experience of the escalation process was in NHS 24, where I was a member of the Advice and Assurance Group that was appointed by the Scottish Government to support the NHS Board, following their escalation to Stage Three of the Performance Management Framework. In NHS Tayside I was appointed interim Chair of the NHS Board after the resignation of the previous Chair in response to the escalation of the health board to Stage Five of the Performance Management Framework. In 2022, Susan Wallace and I were commissioned to undertake a review of corporate governance in NHS Forth Valley as part of the NHS Board's response to being escalated to Stage Four of the Framework. Therefore, I understand the Performance Management Framework from several different perspectives.

109. In principle, the deliberate lack of detail around the approach to be adopted to interventions by the Scottish Government is designed to provide a flexible approach to the level of support provided to health boards by the Directorates for Health and Social Care. This means that the Scottish Government's response is tailored to meet the specific circumstances faced by the health board at the time the decision to escalate is made. As a result, the individuals appointed to support this process changes on each occasion the escalation process is used by the Scottish Government to ensure services and targets are being delivered within budgets and with the appropriate governance.

110. Therefore, the effectiveness of the escalation process is influenced by the skills, experience, and behaviours of those involved in the Transformation team appointed by the Scottish Government and the approach adopted by the Oversight Board in managing the situation.

111. In the case of NHSGGC, the role of the Oversight Board and the Transformation team was decided by the Scottish Government who can provide the terms of reference of the Oversight Board. The specific responsibilities of the Transformation team members should also be available from the NHS Scotland Health & Social Care Management Board.

112. As far as the effectiveness of the Transformation team is concerned, the complexity of the situation meant that some of the issues being addressed were outside the experience of some of the individuals involved. As a result, it proved difficult at times to reach a consensus view on what had occurred or the underlying cause of some of the serious concerns being considered by the Transformation team. Consequently, there were delays in resolving issues and this had an impact on the overall effectiveness of the escalation process and the time taken to reach a position where the decision was made to return NHSGGC to Stage Two of the Performance Management Framework. This lack of consensus was evident in the exchanges between the Transformation and NHSGGC concerning the completion of the report of the Case Note Review and the Interim and Final Reports of the Oversight Board.

113. Throughout my term as NHS Board Chair, the Board and the Standing Committees continued to operate in line with the principles of good governance described in the NHS Scotland Blueprint for Good Governance.

114. The NHS Board was not represented on the Oversight Board, but I did have the opportunity to comment on the terms of reference of the Oversight Board. Although not invited to join the Oversight Board, I was invited to attend their first meeting and I had access to the minutes of subsequent meetings.

115. I also had several one-to-one meetings with the chair of the Oversight Board, Professor Fiona McQueen. These were at my request as I required assurance on behalf of the NHS Board that the Oversight Board and the Transformation team were receiving the appropriate level of support and information from NHSGGC for them to function effectively. Professor McQueen gave that assurance on every occasion we met.

116. During my two terms as NHS Board Chair, I reported directly to four Scottish Government Ministers: Ms Shona Robison, Ms Jeanne Freeman, Mr Humza Yusaf, and Mr Michael Matheson. I had regular informal discussions with all four Cabinet Secretaries on the progress being made to address the issues and concerns that had arisen around the hospital environment and the NHSGGC's management of this situation, including the approach adopted to supporting and communicating with the patients and their families.

117. During the period that the health board was escalated to Stage Four of the Performance Management Framework, Ms Freeman often raised her concerns about the level of trust placed in the organisation concerning the safety of the hospital environment and questioned the effectiveness of the NHSGGC approach to communications.

118. The organisation's culture and leadership were also raised as a concern on several occasions by Ms Freeman. Although she did reassure me during these conversations that she had faith and confidence in the Chair and Chief Executive's ability and commitment to resolving the situation and this is reflected in her request that I accept her offer of a second term as NHS Board Chair in 2019. Mr Yusaf and Mr Mathieson also expressed their ongoing support for the Chair and Chief Executive during their terms as Cabinet Secretary for Health and Social Care.

119. In response to the escalation of NHSGGC to Stage Four of the Performance Framework the NHS Board commissioned an independent review of the Board Member's effectiveness from the Quality Governance Collaborative of the Royal College of Physicians of Edinburgh. The review was conducted by Professor Michael Deighan, a highly regarded expert in governance in healthcare. The review report was shared with the Scottish Government and is available from NHSGGC. The recommendations and the recommendations in the report and the findings of the Board Members self-assessment of Board effectiveness were brought together in a continuous improvement programme that was reviewed and updated on a regular basis by the NHS Board. A copy of the Board Development Programme is also available from NHSGGC.

The Case Note Review

120. The Case Note Review was established by the Scottish Government in 2020. The terms of reference for the review and the methodology employed for the review team were decided by the Oversight Board. NHSGGC clinicians were involved in discussions on how the Review team would be supported, including what evidence would be appropriate for consideration by them.

121. In its final report to the Oversight Board the Review team described the difficulties they experienced in identifying specific sources of infection and presented a range of scenarios in respect of the role of the hospital environment as a possible or probable source of infection. The Review team made several recommendations that were relevant to either NHSGGC and/or NHS Scotland.

122. Although the NHSGGC Medical Director expressed some reservations concerns around the methodology employed by the Case Note Review, the Oversight Board were content that all the relevant evidence had been taken into account by Review Team. The Oversight Board's response was accepted by the Medical Director and on that basis, the NHS Board accepted the recommendations for NHSGGC. Details of the specific areas of concern raised by the Medical Director and the Oversight Board's response can be obtained from NHSGGC and the Oversight Board.

123. A media statement reflecting the Board's position at that time was issued following the publication of the Case Note Review report. This statement apologised for the distress caused to patients, their families, and our staff, described the remedial action already taken, and emphasised the organisation's commitment to implementing the recommendations from the Review.

124. The recommendations from the Case Note Review were integrated into the action plan that included all the recommendations from the previous external reviews and the Oversight Board Interim and Final Reports. The delivery of this plan was overseen by the Scottish Government as part of the work of the Oversight Board. It was as a result of the Oversight Board being assured that all the recommendations had been implemented and the action plan completed,

that NHSGGC was de-escalated to Stage Two of the NHS Scotland Performance Management Framework.

125. As my second term as NHS Board Chair ended in November 2023, I was not involved in any discussions that resulted in the NHS Board's decision in 2024 to revisit NHSGGC's acceptance of the findings and conclusions of the Case Note Review. Therefore, I cannot comment on the Board's most recent submissions to the Scottish Hospitals Inquiry that NHSGGC does not accept that anything contained in the Case Note Review can properly justify any adverse inference about the safety of the water, drainage or ventilation systems at the new hospitals. The current NHS Board Chair, Lesley Thomson KC would be best placed to answer questions on this matter.

Remediation Works

126. A significant programme of remediation works has been undertaken by NHSGGC since the point of handover of the new hospitals in 2015. This includes work on the water system and the ventilation system. Full details of this work have been provided to the Inquiry team by NHSGGC.

Summary

127. The information provided in this statement refers to my role as Chair of NHS Greater Glasgow and Clyde from December 2015 to November 2023.

128. Following the opening of the QEUH and the RHC in 2015, it became obvious that the construction of the QEUH and the RHC had failed to deliver what had been expected by the Scottish Government in relation to the quality of the hospital buildings when they agreed to invest in the new hospitals.

129. The full details of all aspects of what was an extraordinarily complex situation, including the Board Members involvement in resolving the issues that required to be addressed, have been made available to the Inquiry team and include Minutes of meetings, internal reports, and external reviews of the QEUH Campus.

130. As I am not aware of the information available to the NHS Board at the planning, design, commissioning, or handover stages of the construction of the QEUH and the RHC, it would not be appropriate for me to comment on decisions or actions taken by NHSGGC prior to December 2015. This includes whether the built environment was safe and fit for purpose at the time of handover in January 2015 or whether a phased handover would have been more beneficial than handing the buildings over all at once.

131. I also do not consider myself qualified to provide an opinion with regards to whether any specific infection or outbreak of infection can be linked to the hospital environment. As set out in the NHS Scotland Blueprint for Good Governance, the active approach to corporate governance requires Non-Executive Board Members to take assurance from several sources, including the professional advice of the senior clinicians in the organisation and any other experts who have had access to all the evidence. This was the approach adopted by the NHS Board in relation to whether the risks around infection prevention and control were being identified, recorded, and mitigated. Details of role played by Non-Executive Board Members play in challenging and scrutinising management decisions related to hospital environment safety are contained in the minutes of the NHS Board and the Standing Committees.

132. Throughout my time as Board Chair, the NHS Board followed an approach to governance consistent with the model described in the NHS Scotland Blueprint for Good Governance. This included adopting a continuous improvement approach to the corporate governance arrangements in NHSGGC that provided the Board Members with assurance that the concerns around the safety of the hospitals were actively investigated and addressed by the Corporate Management Team.

133. However, it should be recognised that the complex nature of the situation and the difficulty in reaching a consensus about the possible cause of the risk of healthcare acquired infections resulted in delays in identifying the remedial action required. Once these difficulties had been overcome, often by seeking external expert advice, action was taken to improve the quality of the hospital environment and mitigate the risk of infections.

134. The Scottish Government provided additional financial support to NHS GGC to remedy the situation and as most of these costs relate to failures in the quality of the construction of the new hospitals, legal action has been taken against the construction company and the NHSGGC professional advisors to recover these costs. This reflects the extent to which the NHS Board considers the construction company and the NHS Board's professional advisors accountable for the challenges that NHSGGC faced following the opening of the QEUH and the RHC.

135. Although I have found no evidence of any deliberate attempt to withhold relevant information from any of the key stakeholders in the quality of healthcare provided by the QEUH and RHC, I accept that while the cause of infections was still being determined, communications with patients and their families could have been more effective. I regret the distress this caused and have apologised to the families affected on behalf of NHSGGC. In hindsight, this is an area where the NHS Board and I could have been more engaged.

136. I also accept that the failure to either implement the recommendations made in the DMA Canyon risk assessment reports could have had the potential to increase the likelihood of risks to patient safety. However, the failure to detect this operational failure or escalate the issue to senior management does not reflect a 'cover up' by NHSGGC. This is a case of a failure by certain individuals to effectively perform their duties, rather than a deliberate attempt by the organisation to ignore a potential risk to patient safety.

137. I have no concerns around the effectiveness of the NHSGGC approach to whistleblowing during my time as Board Chair. Both the review of the response to the specific concerns raised about the safety of the hospital environment and the review of the policy and procedures that underpinned the handling of those concerns confirmed that the system was fit for purpose and applied appropriately to the cases concerning the hospital environment.

Declaration

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Professor John Brown CBE

August 2025

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

Appendix A

A43255563 - Bundle 1 - Incident Management Team Meeting Minutes (IMT Minutes)

A43273121 - Bundle 3 - NHS National Services Scotland: SBAR Documentation

A43299519 - Bundle 4 - NHS Greater Glasgow and Clyde: SBAR Documentation

A43296834 - Bundle 5 - Communications Documents

A43293438 - Bundle 6 - Miscellaneous documents

A43955371 - Bundle 8 - Supplementary Documents

A47390519 - Bundle 11 - Water Safety Group

A48890718 - Bundle 13 - Additional Minutes Bundle (AICC/BICC etc)

A49525252 – Bundle 14, Volume 1 – Further Communications

A49541141 – Bundle 14, Volume 2 – Further Communications

A47664054 - Bundle 15 - Water PPP

A48245730 - Bundle 18, Volume 2 - Documents referred to in the expert report of Dr J.T. Walker

A48946859 – Bundle 20 - Documents referred to in the Expert Reports by Andrew Poplett and Allan Bennett

A49618520 – Bundle 23 - Queen Elizabeth University Hospital and Royal Hospital for Children, Isolation Rooms PPP

A49799834 – Bundle 27, Volume 4 - Miscellaneous Documents

A49847958 - Bundle 27, Volume 5 - Miscellaneous Documents

A50002331 - Bundle 27, Volume 7 - Miscellaneous Documents

A50976013 – Bundle 29 - NHS Greater Glasgow and Clyde Audit Reports

A50976005 – Bundle 29 - NHS Greater Glasgow and Clyde Audit Reports

A50976001 - Bundle 29 - NHS Greater Glasgow and Clyde Audit Reports

A33474856 –Bundle 52, Volume 1 – Miscellaneous Documents

A52378408 – Bundle 52, Volume 1 – Miscellaneous Documents

A39495998 – Bundle 52, Volume 1 – Miscellaneous Documents

A39495969 – Bundle 52, Volume 1 – Miscellaneous Documents

A33474856 –Bundle 52, Volume 1 – Miscellaneous Documents

A44777296 – Bundle 52, Volume 2 – Miscellaneous Documents

A49847577 - Hearing Commencing 19 August 2024 - Witness Bundle - Week Commencing 2 September 2024 - Volume 3

A50766285 - Hearing Commencing 19 August 2024 - Day 35 - 24 October 2024 - Transcript - Professor Craig White

Appendix B

Professor John Brown CBE

MBA, ACMA, GCMA, FRCP Edin, FInstLM, FCICM

PROFILE

An accomplished executive director with over 40 years' experience of driving up performance and leading public facing organisations through transformational change. A chartered management accountant and former finance director with extensive operational management experience, using quality management systems and programme management techniques to improve service delivery, achieve targets and drive down costs.

An influential chair and governance advisor having successfully pursued a portfolio career at Board level, using experience and understanding of operational management, leadership of change and corporate governance to

create a shared vision of the future and realise the organisation's potential to deliver successful outcomes for the community it serves.

An inclusive and collaborative leader with experience of the UK healthcare, education, tax and welfare systems and an extensive network of professional contacts across the public sector, including Ministers, national and local politicians, and government officials.

CURRENT ROLES

Executive Director of Corporate Services,
St Margaret of Scotland Hospice
May 2024 to date

The St Margaret of Scotland Hospice is the largest hospice in Scotland and is widely regarded as a centre of excellence for the delivery, research, and teaching of specialist palliative and hospital-based complex clinical care. Patients come from the Greater Glasgow and Clyde area and in addition to inpatient care, the Hospice offers day care, community specialist palliative care and counselling services. Founded in 1950 by the Religious Sisters of Charity, the Hospice continues to uphold the principles of the Catholic faith, providing care that is holistic and considers the spiritual, physical, psychological, and social needs of its patients and their families. The Hospice cares for patients and employs staff from all communities, irrespective of their religion or belief.

The Executive Director of Corporate Services has overall responsibility for the day-to-day management of all non-clinical operational and administrative functions of the Hospice. This includes responsibility and accountability for leading, directing, planning, and managing the finance, fundraising, human resources, governance, administration, facilities, building maintenance, IT services, information systems and cyber security functions of the Hospice. The Executive Director for Corporate Services also has responsibility for the development and maintenance of the corporate risk system and business continuity plans.

The Hospice is a Company with charitable status, limited by guarantee, and in addition to functioning as an Executive Director, the postholder has been a Company Member and a Trustees of the Charity since January 2024.

Advisory Board Member,
University of Strathclyde Centre for Health Policy
Dec 2023 to date

The University of Strathclyde Health Policy Unit was established in 2014 as an academic hub for fresh perspectives on healthcare and public health policy. The Unit's current cross-disciplinary activities cover reducing health inequalities, mental health and understanding long-term changes in health and wellbeing and their relationship to economic, social and health policies.

The Advisory Board works to support health policy research, strengthen and broaden connections with external organisations, increase research impact via public and policy engagement, and develop health policy teaching and training.

Advisory Board Member,
University of Dundee School of Business
Dec 2019 to date

The University of Dundee's School of Business is the UK's newest and fasted-growing business school. Its primary aim is to contribute and add value to its communities through excellence in teaching, research, and community engagement.

The Advisory Board provides critical advice to the University Principal and School Executive on the direction of the School of Business, advising on stakeholder engagement and collaboration and promoting the University of Dundee and its School of Business locally, regionally, and internationally.

Senior Faculty Member,
Royal College of Physicians of Edinburgh
Oct 2017 to date

The Royal College of Physicians works in collaboration with the World Health Organisation, governments, universities, and health and social care providers to determine appropriate responses to the challenges faced in the governance of health and social care systems across the globe.
The College's Quality Governance Collaborative brings together multi-professional groups to shape international corporate governance practice,

ensuring that integrated health and social care systems continue to deliver the best possible outcomes for the population and communities they serve.

CAREER HISTORY

Chair, Hub East Central Scotland Ltd
Oct 2023 to Feb 2025
Hub East Central Scotland Ltd is a public and private sector partnership delivering new community infrastructure across Falkirk, Clackmannanshire, Stirling, Perth & Kinross, Dundee, Angus, and Fife.

The Company offers expertise in strategic development, value driven procurement and project management and provides Local Authorities, NHS Boards, the Scottish Ambulance Service, Police Scotland and the Scottish Fire and Rescue Service with a platform and mechanism to deliver and manage buildings more effectively. Working collaboratively with central and local government partners, Hub East Central Scotland has delivered over 60 major construction projects with a combined value exceeding [redacted]

Chair, NHS Greater Glasgow and Clyde
Dec 2015 to Nov 2023
NHS Greater Glasgow and Clyde is the largest healthcare system in the UK with an annual budget of [redacted] employing over 40,000 staff to deliver local, regional, and national healthcare services to a population of over 2.1 million people. The Board Chair is directly accountable to the Cabinet Secretary for Health and Social Care for improving health at population level and creating an integrated health and social care system that meets the present and future needs of the people of Greater Glasgow and Clyde.

To deliver this ambition the Chair must ensure that the NHS Board engages with key stakeholders to develop strategies and plans that focus on improving population health and addressing health inequalities, while delivering high quality, sustainable, person centred and effective health and social care services. At the same time the Board needs to hold the executive leadership

team to account for the delivery of services and the deployment of resources, including staff. The Board must also influence the leadership approach within the organisation to ensure an appropriate organisational culture is in place. Considerable progress towards the achievement of these goals in NHS Greater Glasgow and Clyde was delivered by the Chair taking the following actions:

- Encouraging and facilitating strategic partnerships with the extensive range of public and private sector organisations who influence the health and wellbeing of individuals and communities across Greater Glasgow and Clyde
- Engaging with the executive leadership team to identify areas for improvement across the full range of local, regional, and national health and social care services, including the development and implementation of post pandemic remobilisation and recovery plans for urgent and elective care
- Prioritising activities to increase the organisation's capability and capacity for transformational change, in order to improve performance, reduce costs and ensure sustainability and resilience
- Introducing an active governance approach and assurance framework that integrates and improves strategic planning, risk management and assurance information flows at Board level
- Recruiting a well-balanced and diverse NHS Board capable of addressing equality, diversity and inclusion issues in their deliberations and decision making
- Developing and promoting a collaborative and compassionate leadership approach to shape the organisational culture and improve relationships at national and local government level
- Leading the Board's response to the failures in the design and construction of the Queen Elizabeth University Hospital campus, prioritising the restoration of public confidence in the safety and quality of care provided in the hospitals
- Promoting initiatives to ensure the health and wellbeing of staff at all levels during the Coronavirus pandemic

In addition, the NHS Board Chair also functioned as Chair of the Glasgow Centre of Population Health and the NHS Greater Glasgow and Clyde Endowment Fund.

The Glasgow Centre for Population Health exists to generate insights and evidence, support novel approaches, and inform and influence action to improve population health and wellbeing and tackle inequality. Working with a wide range of stakeholders, the Centre conducts research of direct relevance to policy and practice, facilitates and stimulates the exchange of ideas, fresh thinking, and debate to support development and change, not only in Scotland but worldwide.

The NHS Endowment Fund is a registered charity with the primary objective of the advancement of health for the population of Greater Glasgow and Clyde. The charity has an annual income of around [redacted] and holds funds of [redacted] in trust. A sizeable proportion of the Endowment Fund is allocated each year to support research and innovation in healthcare.

Prior to being appointed Chair, served as a non-executive member of the NHS Greater Glasgow & Clyde Board from January 2015. This included membership of the management boards of the Glasgow City Health & Social Care Partnership and the Renfrewshire Health & Social Care Partnership.

Co- Chair, Glasgow Health Sciences Partnership
Dec 2015 to Nov 2023

The partnership with the University of Glasgow aims to integrate world-leading research, top quality education and expertise in clinical practice across the University and NHS Greater Glasgow and Clyde. This approach is built on enabling a culture where clinicians are encouraged to be aware and active in research activities as part of their daily work.

The Health Sciences Partnership's annual work programme includes over 300 research projects and initiatives to support innovation in healthcare. The clinical trials associated with this research include around 8,000 patients each year. The following list gives examples where research and innovation have contributed to the improvement of healthcare:

- Research into the impact and treatment of the Covid-19 virus, both in the short and longer term

- Research into the causes and treatment of cancer with significant funding and activities channelled through the Beatson West of Scotland Cancer Centre
- Development of a public/private partnership and funding of [redacted] to promote Precision Medicine through innovation and capability building in data analytics, diagnostics and genomics
- Establishment of an Innovation Zone to provide space and facilities for industry partners to focus on major disruptive innovation and change

These programmes and numerous other research projects have resulted in Glasgow being considered among the world leaders in healthcare research, development, and innovation.

Chair, NHS Scotland Global Citizenship Advisory Board

Oct 2017 to Mar 2024

The NHS Scotland Global Citizenship Advisory Board supports Scotland's international development commitments as set out in the Scottish Governments' International Development Strategy, in particular the commitment to support capacity strengthening in population health and wellbeing.

The Advisory Board provides advice to Ministers, officials, and NHS Boards on how NHS Scotland can support population health and wellbeing in low and middle income countries at a strategic and organisational level. This work has included expanding the NHS approach to global citizenship beyond international volunteering to encompass broader issues such as planetary health, climate change and health inequalities. Projects and initiatives that have contributed to developing the NHS Scotland approach to global citizenship include:

- Developing and delivering a comprehensive programme of activities to address the recommendations of the Royal College of Physicians and Surgeons of Glasgow's 2017 report titled 'Global Citizenship in the Scottish Health Service'
- Establishing a Global Health Co-ordination Unit to provide a central point for advice and support to NHS Boards and their staff

- Introducing a tripartite health partnership between Malawi, Zambia, and Scotland, facilitated by the World Health Organisation, which aims to achieve sustainable improvements in the quality of healthcare through the mutual exchange of knowledge and skills and co-development of solutions to deliver the ambitions of each partner country
- Revising national HR policies to recognise global health volunteering as part of Continuing Professional Development across all NHS staff groups
- Publishing guidance on the 'Once for Scotland' approach required for donations of medical equipment by NHS Boards to low and middle income countries

As Advisory Board Chair also initiated projects to identify new options for improving the flow of charitable funds to NHS staff participating in global citizenship activities and introduce an 'Investors in Global Citizenship' scheme that describes best practice and supports NHS Boards on their journey towards achieving the 'Gold Standard' in supporting global citizenship in the NHS.

Chair, NHS Scotland Corporate Governance Steering Group

Oct 2017 to Nov 2022

The Corporate Governance Steering Group had responsibility for setting the standards for corporate governance in NHS Scotland. This involved developing and maintaining a 'Once for Scotland' blueprint to define the functions, enablers and support required of an effective governance system across the 22 NHS Boards.

As the Chair of the Steering Group and the author of the NHS Scotland Blueprint for Good Governance, the role primarily involved providing advice to Scottish Government Ministers, government officials and NHS Boards on best practice in health and social care governance and ensuring that the agreed way forward was rolled out across NHS Scotland. This not only required awareness of the latest research into good governance but also ongoing engagement with the key players in the governance of NHS Scotland, including the Scottish Government, Local Authorities, the NHS Board Chairs, Chief Executives and NHS Education for Scotland.

The activities undertaken to improve the governance arrangements for health and social care across NHS Scotland include:

- Recommending changes to the governance systems in NHS Forth Valley, NHS Highland and NHS Tayside following delivery of external reviews based on the Blueprint for Good Governance
- Providing assurance to the Cabinet Secretary on the rollout of a new IT system for NHS 24
- Commissioning and approving new induction and skills training for Board Members
- Developing an original approach to reviewing Board effectiveness
- Promoting a culture of active governance and supporting the rollout of this across NHS Boards
- Partnering with NHS Education for Scotland to develop on-line support for Board development

This work on improving the governance of health and social care across NHS Scotland culminated in the publication of a second edition of the Blueprint for Good Governance in October 2022. This places more emphasis on the delivery mechanisms and the need to apply a continuous improvement approach to health and social care governance arrangements. The governance of change now features more prominently in the description of best practice and the updated guidance on implementing the Blueprint also highlights the need for NHS Boards to adopt both active and collaborative approaches to governance.

Independent Director, Culture & Sport Glasgow

February 2020 to Mar 2021

Culture & Sport Glasgow (trading as Glasgow Life) is a charity that delivers cultural, sporting and learning activities on behalf of Glasgow City Council, for the benefit of citizens and visitors. It aims to make a positive impact on individuals, the communities in which they live and the city as a whole by delivering a range of services including arts, music, sports, events and festivals, libraries, community development and learning programmes. Over 19 million people attend Glasgow Life's facilities and events each year.

Glasgow Life manages 171 venues and sites across every part of the city, is responsible for a budget of [redacted] employs around 2,660 staff and is supported by more than 850 regular volunteers.

Interim Chair, NHS Tayside

Apr 2018 to Dec 2019

NHS Tayside provides a comprehensive range of acute, primary, and community-based health services for the 415,000 people living in Dundee City, Perth & Kinross, Angus and North East Fife. The Board employs around 14,000 staff and is responsible for a budget of [redacted]

Following the resignation of the previous Chair and Chief Executive, the interim Chair was appointed by the Cabinet Secretary with the remit of working with the executive leadership team to stabilise the organisation, introduce more effective governance arrangements and develop a transformation programme that would deliver financial balance and sustainable improvements in service delivery.

During the time at NHS Tayside the interim Chair worked closely with the interim Chief Executive and the executive leadership team to stabilise the situation and restore public confidence in the leadership of the organisation by:

- Implementing the recommendations of the external review of governance arrangements commissioned by the interim Chair
- Recruiting new Board Members with experience of transformational change in the public sector
- Leading the refresh of the NHS Tayside change programme, known as 'Transforming Tayside'
- Supporting the Finance Director in developing a credible three-year financial strategy that was agreed by the Scottish Government
- Recruiting a permanent Chief Executive and supporting the transition from an interim to a permanent leadership team at Board level
- Engaging with Ministers and national and local politicians to manage their expectations and gain their support for the changes required

- Handling media enquiries and giving interviews on TV and radio to ensure the public were aware of the progress being made by the organisation

During this period the NHS Board Chair also acted as Co-Chair of the Dundee Academic Health Sciences Partnership, a collaboration with the University of Dundee to promote education, lifelong learning, research and quality improvement in health and social care across Tayside.

Company Secretary, Student Loans Company

Oct 2013 to Dec 2015

The Student Loans Company is a non-profit making Government owned organisation, providing [redacted] per annum in loans and grants to students at universities and colleges across the UK. The Company plays a vital role in supporting the Higher Education and Further Education sectors by delivering assessment, payment and repayment services and managing a [redacted] loan book.

In addition to the usual Company Secretary remit for corporate governance, the role also included responsibility for legal advice, regulatory compliance, and internal audit services. Achievements in this role included:

- Redesigning the end-to-end corporate governance system following in-depth reviews of Board effectiveness, risk management, information security governance and internal audit arrangements
- Negotiating the Company's sponsorship agreement and performance management framework with the Department for Business Industry and Skills
- Securing exemption from regulation by the Financial Conduct Authority

As Senior Information Risk Owner, also advised the executive leadership team on the effectiveness of information risk management across the organisation and provided assurance to the Board and the UK Cabinet Office on the effectiveness of the governance arrangements for the digital transformation being delivered in partnership with the Government Digital Service.

Civil Servant, HM Revenue & Customs

Apr 2002 to Mar 2013

As a senior civil servant held a variety of challenging leadership roles following the integration of the Inland Revenue and HM Customs and Excise. During this period gained extensive experience of collaborating with key stakeholders to create a shared vision of the future and develop the organisation's potential. Roles involved leadership of up to 18,000 people in a network of 164 offices across the UK, managing budgets up to £580 million and collecting £240 billion in tax and excise duties. Posts included:

- Director Central Compliance Operations (2011 to 2013)
- Director Cross Cutting Group (2008 to 2011)
- Compliance Director, Wales, Scotland, and Northern Ireland (2007 to 2008)
- Finance Director, Debt Management and Banking (2006 to 2007)
- Director, Debt Management Operations (2005 to 2006)
- Director, Accounting and Payments Service (2002 to 2005)

These roles required working as both an Operations Director and as a Change Programme Director to deliver business as usual and transformational change at the same time. All these roles involved building management capability and capacity to better understand customer behaviour and promote a culture of continuous improvement built around quality management, employee engagement and teamwork. This introduction of modern management techniques created a learning organisation that ensured delivery of key operational targets, within budget and to the quality standards set by Government Ministers.

QUALIFICATIONS & MEMBERSHIPS

- Master of Business Administration, University of Glasgow (1997)
- Chartered Management Accountant, Chartered Institute of Management Accountants (2013)
- Fellow, The Royal College of Physicians of Edinburgh (2021)

- Fellow, The Institute of Leadership and Management (2011)
- Fellow, The Chartered Institute of Credit Management (2006)

HONOURS

- Appointed CBE for significant contribution to improving leadership in the Public Sector
- Appointed Honorary Professor at University of Dundee, School of Business for work with the Business School on the governance and the leadership of transformational change

  Appointed Honorary Professor and Senior Research Fellow at University of Glasgow, College of Medical, Veterinary and Life Sciences for contribution to research and innovation in health sciences.