

1 Tuesday, 15 September 2026 2 (10.06 am) 3 THE CHAIR: Good morning. Please have a seat. Yes, 4 Mr Dawson. 5 MR DAWSON: Good morning, sir. The first witness this 6 morning is Robbie Pearson. 7 THE CHAIR: Thank you. 8 MR ROBBIE PEARSON (affirmed) 9 Questions by COUNSEL TO THE INQUIRY 10 MR DAWSON: Thank you, sir. You are Robbie Pearson? 11 A. I am. 12 Q. Mr Pearson, while giving evidence if you could try as 13 best you can to speak into the microphone and if, for 14 any reason, you require a break at any stage please feel 15 free to say. 16 A. Thank you. 17 Q. You have provided a witness statement in response to 18 a Rule 8 request for the Inquiry on behalf of Healthcare 19 Improvement Scotland; is that correct? 20 A. That's correct. 21 Q. And you're the Chief Executive of that organisation? 22 A. I am. 23 Q. Could we have up on the screen, please, HIS-00047. Is 24 that the witness statement that you have provided to the 25 Inquiry? Page 1	1 Q. And you tell us in your statement that while you were 2 a general management trainee at Ninewells you were 3 working in the office of the trust chief executive, is 4 that right? 5 A. That's correct. 6 Q. So you had no direct contact with any of the 7 neurosurgical operations with which we're concerned in 8 this Inquiry? 9 A. That's correct. 10 Q. Thank you. And you've been chief executive of 11 Healthcare Improvement Scotland, as I understand it, 12 since 2016? 13 A. That's correct. 14 Q. And the organisation has been in existence since 2011? 15 A. That's correct. 16 Q. Before you -- in your statement you describe yourself as 17 the "accountable officer" of the organisation. Can you 18 tell us what that means? 19 A. Yes, so the accountable officer is ultimately 20 responsible -- the personal accountability delegated to 21 me by the chief executive of the NHS of Scotland. And 22 in that personal accountability, as the accountable 23 officer, I have a role in ensuring the proprietary 24 regularity and stewardship of the finances of the 25 organisation but a broader responsibility ensuring it Page 3
1 A. It is. 2 Q. Could we go to page 47, please. Does your signature 3 appear there underneath the bit that's blocked out? 4 A. Indeed it does. 5 Q. Is the statement dated 16 March 2026? 6 A. Yes. 7 Q. And are the contents of this statement true as far as 8 you're concerned? 9 A. They are. 10 Q. Thank you very much. Mr Pearson, you give us some 11 information in your statement about your background. 12 I understand that you have an honours degree, an MA in 13 economics and management from St Andrews University; is 14 that correct? 15 A. That's correct. 16 Q. And after graduating from St Andrews University you and 17 joined the NHS general management training scheme 18 in 1992; is that correct? 19 A. That's correct. 20 Q. And during this training you spent some time at Aberdeen 21 Royal Infirmary in 1992-1993, is that right? 22 A. That's correct. 23 Q. Indeed you spent some time in Ninewells Hospital in 24 Dundee in 1993; is that correct? 25 A. That's correct. Page 2	1 upholds good practice governance in relation to the 2 organisation as a whole. 3 Q. Thank you. And the role of accountable officer does 4 that come from statute or is it an internal arrangement 5 within the NHS? 6 A. So that comes from statute, in relation to the 7 accountable officer memorandum and that is delegated to 8 individual chief execs in NHS Scotland by the chief 9 executive of the NHS and director general of the health 10 service in Scotland. 11 Q. Okay, and to whom are you accountable? 12 A. So I'm accountable to the board of Healthcare 13 Improvement Scotland. I have an accountability via 14 Scottish Ministers as well ultimately to parliament in 15 respect of the operation and delivery of the work of 16 Healthcare Improvement Scotland. 17 Q. And presumably an accountability to the people who rely 18 upon the services that your organisation provides? 19 A. Absolutely and a point in relation to the establishment 20 of Healthcare Improvement Scotland is the overall 21 general duty to further improvement in the quality of 22 healthcare in Scotland but also what parliament 23 entrusted us with was to protect and enhance the safety 24 and well-being of those in need of healthcare, whether 25 in the NHS or indeed the independent sector. Page 4

1 Q. When you say -- you mentioned having to account to the 2 government but also to parliament, is the accountability 3 to parliament direct or is it indirect as the same way 4 as government is accountable to parliament? 5 A. It's indirect to parliament. I don't have the 6 accountability to parliament like the auditor general 7 would have of Audit Scotland so it's a different 8 accountability, it's indirect. But ultimately I have 9 an accountability through health and sport committee, 10 for instance, where I may be required to give evidence. 11 Q. Understood. We heard, for example, from the Patient 12 Safety Commissioner for Scotland last week a role 13 which -- no doubt, you're familiar with that role? 14 A. Yes. 15 Q. That she has -- in her role she has an accountability 16 directly to parliament, but that's not the same 17 arrangement as far as you're concerned; is that correct? 18 A. That's correct. 19 Q. You also tell us in your statement that you were 20 previously the organisations deputy chief executive and 21 director of scrutiny and assurance between 2012 and 22 2016. What is scrutiny and assurance in that role? 23 A. So in that role -- this was the first role that had been 24 established in Scotland, been establishment in 25 Healthcare Improvement Scotland and the role of scrutiny Page 5	1 Q. And that method, if you like that methodology of the 2 Healthcare Improvement Scotland becoming involved, just 3 to understand that, there was effectively a member of 4 the staff of that health board who had concerns about 5 the way things were being run, is that right? 6 A. Yes, correct. 7 Q. And in particular concerns were expressed or understood 8 to exist within the adverse event reporting system is 9 that right? 10 A. That's correct. 11 Q. And then those came to the attention of Scottish 12 Government through an individual who was working within 13 the board? 14 A. Yes, he was. 15 Q. And at that point Scottish Government took the decision 16 that it would be a good idea and within its competency 17 for Healthcare Improvement Scotland to become involved 18 and to investigate those allegations and concerns, is 19 that right? 20 A. Correct. 21 Q. And you mentioned that what was done there was then 22 rolled out across other NHS boards in Scotland, is that 23 right? 24 A. That's right. 25 Q. Can you explain the process by which that was done, did Page 7
1 and assurance in that time was to provide leadership for 2 inspections, reviews of individual services, and those 3 were generally carried out based on standards that had 4 been developed within Healthcare Improvement Scotland. 5 Q. Okay, we'll get on to some of the details of those 6 systems in due course. You also say in that role 7 a major initial priority on assuming the role was to 8 review the management of adverse events in NHS Ayrshire 9 and Arran which was subsequently extended to all NHS 10 boards in the following two years. Could you tell us 11 just a little bit about what it was that necessitated 12 a review of adverse events in Ayrshire and Arran 13 initially? 14 A. Yes, so a whistleblower, a psychiatric nurse, 15 Rab Wilson, raised a number of concerns about the 16 management of adverse events in Ayrshire and Arran and 17 it particularly affected him because he was a member of 18 staff in that service and he had felt he had not been 19 involved in the formulation of the adverse events or 20 indeed learning from that. He raised those concerns 21 with Scottish Government and Scottish Government asked 22 us, as I arrived at Healthcare Improvement Scotland, to 23 carry out a review into the management of adverse events 24 in Ayrshire and Arran and to take the learning from that 25 and recommendations into the wider system. Page 6	1 that involve an inspection of them in that regard or 2 involve learning the experience from Ayrshire and Arran 3 experience being rolled out across Scotland? 4 A. So in those boards, across the patient-facing boards in 5 Scotland -- if that's the right way of describing it, 6 those boards delivering direct care -- we took the key 7 recommendations -- a number of the key recommendations 8 from the Ayrshire and Arran review and sought to 9 establish a baseline, as it were, as to how health 10 boards were performing against those recommendations and 11 to inform future approach to the framework for adverse 12 events. And that took place following the publication 13 of the review in Ayrshire and Arran in June 2012 and 14 took fully the best part of a year, 18 months to 15 conclude that piece of work, when going around those 16 individual boards to assess where they sat against 17 a number of the -- not all of them, but a number of the 18 key recommendations from the Ayrshire and Arran review. 19 Q. I see. And just on the subject of adverse events, which 20 I think was the focus of that particular review, could 21 you just give us a description what area of the 22 management of a health board that involves? 23 A. So at that point in time we were ascertaining the extent 24 to which the health board, at every level, was engaged 25 in understanding adverse events, how they were Page 8

1 identified, through incident reporting, all the way up 2 through the governance and the chain of command of the 3 health board, if that's the right phrase. 4 Q. So adverse events are situations in which something is 5 perceived to have gone wrong? 6 A. Correct. 7 Q. And that could be gone wrong in clinical care or in the 8 corporate governance of the board, is that right? 9 A. Yes, and also in the framework. Subsequently, we've 10 emphasised that it's not just where things go wrong that 11 are identified but potentially near misses as well. 12 But, yes, in terms of adverse events and how they're 13 categorised is based on a grid assessment of risk and 14 consequences likely to have an impact. 15 Q. So an adverse event system, if I can call that, from 16 what you're telling me should involve not only 17 responding when things go wrong but, as you say, near 18 misses which would be looking at situations in which 19 things perhaps almost went wrong to try to learn from 20 those as well; is that correct? 21 A. Correct. 22 Q. And the purpose of that would be to try to prevent near 23 misses turning into actual adverse outcomes, if that's 24 a way of putting it? 25 A. Correct. Page 9	1 right? 2 A. That's correct. 3 Q. And is that a system which is imposed nationally or is 4 that a system which is developed locally? 5 A. So that's a system that is generally imposed nationally 6 and reflected in the framework and over time there have 7 been various risk or impact grids, if that's the right 8 way to describe it, in which there's a quantification of 9 impact versus likelihood and you get the consequence 10 being either high, or very high. So generally that's 11 what's been adopted in the context of this. 12 Q. And is that system one that came out of the work that 13 Healthcare Improvement Scotland were doing or was that 14 one that pre-existed 2012 when you started that work? 15 A. So if I can categorise in two parts. One is the risk 16 rating system which existed probably pre-2012. The 17 broader point about the framework for learning and the 18 management of adverse events was something that grew out 19 of our work in Ayrshire and Arran and subsequent review 20 of individual boards. 21 Q. So just to give us a little bit of background, the 22 framework for learning you mentioned, what is that 23 broadly? 24 A. So the framework for learning, the first addition of it 25 I think was in September 2013, that Healthcare Page 11
1 Q. Another expression that we've seen in the paperwork, 2 which we may hear more about later this week, is 3 a "serious adverse event review". Is that something 4 you're familiar with? 5 A. Yes. 6 Q. Is that a particular category of adverse event or how 7 does that work? 8 A. So the significant adverse event review is intended to 9 capture level 1 reviews, category 1 reviews. And they 10 are the most significant event based on that grid 11 I described in relation to impact and particularly where 12 it has caused severe harm and ultimately potentially 13 death. 14 Q. And are these systems ones that are run within health 15 boards? 16 A. Yes, they all run within individual health boards, yes. 17 Q. Yes, and what Healthcare Improvement Scotland's role 18 was, was to try to learn from an issue which had been 19 arisen in this area within Ayrshire and Arran and to 20 try, as the body does as we'll come on to, to suggest 21 how things might work better across the board to improve 22 patient care in Scotland? 23 A. Correct. 24 Q. You mentioned there the possibility -- there is a grid 25 with different levels of severity of events, is that Page 10	1 Improvement Scotland produced. And what that did was it 2 took from Ayrshire and Arran, it took from individual 3 boards and actually wider approaches across UK, to 4 management of learning from adverse events. And sought 5 to create, I suppose, a framework in which boards could 6 work within to ensure the consistency in relation to 7 their approach to identification and management of 8 adverse events in Scotland. 9 Q. Okay, I think you mentioned that before that framework 10 of learning came in, which I think you told us 11 Healthcare Improvement Scotland were heavily involved 12 in, in trying to suggest the way systems might work as 13 best they possibly could at optimum level, before that, 14 I think you mentioned there were risk management systems 15 that existed before that; is that correct? 16 A. That's correct. 17 Q. And were -- the issues that had arisen in Ayrshire and 18 Arran, had they arisen under those previous risk 19 management systems? 20 A. I don't believe they had to that same extent. The work 21 that we took forward in Ayrshire and Arran was forensic, 22 it was capturing it from the standpoint of a member of 23 staff who had been left damaged through the whole 24 process of engagement in that health board and in that 25 we identified a number of concerns about openness, about Page 12

1 transparency, learning and accountability. 2 Q. And those learnings were fed into the framework for 3 learning; is that correct? 4 A. Correct, yes. 5 Q. Perhaps I phrased that question incorrectly. The 6 systems that existed, I think you told us there were 7 risk management systems in place that pre-existed the 8 work in 2012 and the framework for learning; is that 9 correct? 10 A. That's correct and in our predecessor body and back to 11 the Clinical Standards Board perhaps -- and I'm going to 12 talk about my predecessor body, it was NHS Quality 13 Improvement Scotland -- there were clinical governance 14 and risk management standards which were subject to peer 15 review over a period of time. 16 Q. Right, and those risk management processes that were in 17 place before the change that you've talked about, were 18 they national standards or were they more locally 19 enforced or devised? 20 A. These were national standards that were devised by NHS 21 Quality Improvement Scotland over a period from around 22 about -- I think it was around 2004 onwards and then 23 they were subject to at least two rounds of peer review 24 of individual boards in Scotland. 25 Q. Okay, and these systems that we're talking about of Page 13	1 sharing intelligence group had its first meeting in 2015 2 and then subsequently the network. 3 Q. We'll come back to the detail of that. 4 Do you know -- you're talking about, I think, 5 important developments through things like the framework 6 for learning, which I think you said came in, 7 in September 2013. Why is it that there is such a big 8 gap between the introduction, if you like, of these 9 clinical governance programmes, these clinical 10 governance measures that were recommended by public 11 inquiries in the late '90s and things like the framework 12 for learning, an important document and development of 13 this aspect of clinical governance in Scotland? 14 A. So I wouldn't say there was necessarily a gap between, 15 say, 1998 and the Inquiry into Bristol. I think there 16 was an evolution of various things over that period of 17 time, the clinical governance risk management standards 18 over a predecessor organisation. When I arrived in 19 Healthcare Improvement Scotland one of the key things 20 I was really keen to ensure was that we were 21 sufficiently forensic in relation to the learning around 22 Ayrshire and Arran because what I firmly believe -- and 23 I firmly believe today -- is a presence of something, 24 a document, a policy, a procedure, is not in itself 25 sufficient. And what we identified in Ayrshire and Page 15
1 adverse event management, which involves, as you have 2 told us, near miss review as well as at the more serious 3 end, serious adverse event reviews or analysis, these 4 are all a feature, are they not, of clinical governance, 5 is that right? 6 A. That's correct. 7 Q. I understand that -- the Inquiry has certainly seen some 8 documentation going further back in time, there were 9 certain developments with regard to clinical governance, 10 important developments that took place in the late 11 1990s, is that right as you understand it? 12 A. Yeah, that's correct, particularly driven by the Bristol 13 Inquiry and serious concerns that arose there in 14 relation to professionalism, ability for people to speak 15 up, aspects of clinical governance and the relationship 16 between boards of governance, all the way down into the 17 front line of services. 18 Q. Another aspect which I know you touch on in some detail 19 actually in your statement which arose, we heard last 20 week, from the Bristol Royal Infirmary Inquiry was the 21 importance of different agencies sharing information. 22 Is that -- that's something I think that Healthcare 23 Improvement Scotland is closely involved in, is that 24 right? 25 A. That's correct, and we've evolved that through -- the Page 14	1 Arran and was a key issue was the extent to which 2 a policy may exist but was actually complied with and 3 followed and that's what we did in a very forensic way 4 by going through these individual adverse event reviews. 5 Q. So that seems like a very important piece of the puzzle, 6 if you like, to try and make healthcare -- to improve 7 healthcare, which is ultimately your organisation 8 agencies objective, one can have a policy and that can 9 be worked up and as sophisticated as possible but if 10 it's not put into practice, then there's really little 11 point in having it, would that be fair? 12 A. Correct. 13 Q. I think -- just to understand, to put it into these 14 investigations which are of interest to us and the role 15 of Healthcare Improvement Scotland to the context of the 16 matters that we are dealing with more directly in this 17 Inquiry, I understand from reading your statement that 18 Healthcare Improvement Scotland has not, at any time, 19 had any role in investigating any aspect of what I might 20 call broadly "the Eljamel saga"; is that correct? 21 A. That's correct. 22 Q. I think your statement mentions the possibility that or 23 that there was a suggestion around about 2023 that 24 Healthcare Improvement Scotland might become involved in 25 devising or contributing in some way to some sort of Page 16

1 clinical review process, is that right? 2 A. Yes, there were two parts to that. There was an initial 3 approach about us providing some support to a review of 4 patient records, case records, a case note review, and 5 the second approach subsequent to that -- or rather, we 6 went back to, sorry, Scottish Government and said was 7 a role was more appropriately in the governance of 8 systems and processes in patient safety and that was 9 in June '23. 10 Q. June '23. So was it in June '23 that the case note 11 review was suggested or was it in June '23 that you went 12 back, if you like? 13 A. So I think the case note review was around about that 14 time in the summer, early summer of 2023. And then 15 subsequent to that we said what would be appropriate for 16 us is to review the systems and processes in governance 17 around the learning and patient safety in the incidents 18 and we left it firmly for Scottish Government to come 19 back to us. 20 Q. I think that's quite an important distinction because 21 I think -- am I correct in thinking that the "case note 22 review" as you've called it, which was being suggested 23 at that time, is what eventual has evolved into what we 24 call the Independent Clinical Review led by 25 Professor Stephen Wigmore, is that right? Page 17	1 like, rather than looking at individual cases, is that 2 right? 3 A. That would be a fair framing, yes. 4 Q. Yes, so both that is the broad remit of your 5 organisation but also that's what you went back and 6 said? 7 A. Yes. 8 Q. I see. And could Healthcare Improvement Scotland have 9 been approached to undertake systemic review of the 10 Eljamel saga at any time since 2011? 11 A. Yes. 12 Q. And if Healthcare Improvement Scotland had been 13 approached to undertake such a review, by whom or by 14 what organisations could they have been so approached? 15 A. We could have been approached by Scottish Government. 16 Could have been approached by NHS Tayside. Those would 17 be the two principal organisations that come to mind. 18 Q. What about the possibility that individuals or groups of 19 patients could have approached you? Is there 20 a mechanism for that to happen within Healthcare 21 Improvement Scotland? 22 A. There isn't a mechanism as such. And I think this would 23 be an interesting point for the Inquiry to reflect on 24 about that mechanism and whether it should exist 25 perhaps, but -- and it may be coming become to the point Page 19
1 A. That would be my impression. 2 Q. Yes. And was it the case at that time, as it is now, 3 that the focus of that process is on individual clinical 4 cases? 5 A. Yes, so it was a very tentative, high-level approach to 6 Healthcare Improvement Scotland we're looking for 7 somebody of standing, eminence to lead the review of 8 case notes and build a relationship, I think Scottish 9 Government described -- I don't have the exact words in 10 the email -- between that case note review and 11 NHS Tayside and learning. 12 Q. And so when you say "a case note review", that would be 13 looking at the medical records, would it? 14 A. Well, we didn't get into that level of detail. It 15 was -- 16 Q. Basically, what is a case note? 17 A. Sorry. A case note review is a look-back exercise 18 across the medical records of individual patients who 19 have been affected. 20 Q. Understood. And I think you said you went back and 21 you -- your organisation gave a response to that 22 tentative proposal? 23 A. Yes. 24 Q. And I think you said that the focus of the response was 25 that your organisation's role was more systemic, if you Page 18	1 about generating intelligence and how we use that 2 intelligence from wherever it comes to inform our 3 actions as an organisation. 4 Q. Because again, to go back to the evidence, which is 5 quite close to the evidence you're giving today given 6 the proximity of the roles that we heard from the 7 Patient Safety Commissioner for Scotland, she explained 8 to us that, as I'm sure you're aware, there is statute 9 underpinning her role which gives her, quite decidedly, 10 a systemic remit. And she gave some evidence in 11 response to questions by me about how one would go about 12 translating, if you like, individual patient experiences 13 into a systemic issue and she was of the view that it 14 was possible that a systemic issue could arise even out 15 of a single complaint in certain circumstances. Do you 16 agree with that proposition? 17 A. So if you look at individual cases over the years and 18 many tragedies, whether it's Mid Staffordshire or 19 Bristol babies, there was one incident, one signal in 20 the system which reflected wider concerns when others 21 came forward to say: we've experienced the same. So 22 definitely yes, it is an important point. 23 Q. You mentioned there the possibility that the Inquiry may 24 wish to reflect on whether there should be access or 25 easier access, if you like, by patients, patient groups Page 20

1 or even individual patients to Healthcare Improvement 2 Scotland. Obviously we have an important remit looking 3 back to what happened but also trying to generate 4 suggestions and recommendations for the future. I would 5 be very interested in your views and reflections on what 6 benefits such a system would bring? 7 A. So I think I would put it in broader terms in relation 8 to there are different pieces of intelligence in the 9 system, whether it's patient experience, whether it's 10 staff whistleblowing, whether there are indicators about 11 safety in relation to infections, how does that all come 12 together to form a considered position and picture about 13 a system which, in isolation, would not be fully 14 understood in the absence of these pieces of that 15 jigsaw. So I think that's certainly a recurrent theme 16 for me is, how do we marshal that intelligence, whether 17 it's the Scottish Service Ombudsman or other agencies 18 coming together to form a rounded picture. 19 Q. Because it is the case, is it not, that where, for 20 example, an individual has suffered an adverse outcome 21 as we discussed, or adverse events, it can sometimes be 22 a case that where the individual case is analysed 23 without looking at the system, if you like, it may be 24 that an individual practitioner or something has done 25 the best they can and no adverse comment is made but the Page 21	1 more direct advice given? 2 A. So I think this is where there's, I suppose, a tension 3 in the current system, as I describe it, because the 4 Patient Rights Act, as formulated, gives an obligation, 5 an onus for boards to engage with individual patients on 6 their complaints and that's how the system works and it 7 is a recourse for appeal and ultimately to the Public 8 Services Ombudsman. I think it then becomes important 9 in that relationship between Healthcare Improvement 10 Scotland and the Scottish Public Services Ombudsman as 11 to where are we picking up patterns of concern and how 12 do those patterns of concern triangulate with other 13 pieces of intelligence perhaps from professional 14 regulators such as the General Medical Council. 15 Q. That's very helpful. Just to understand the system, as 16 we're trying to understand these processes at a kind of 17 elementary level at this stage in the Inquiry. You 18 mentioned there that there is a right, I think, under 19 the Patient Rights (Scotland) Act 2011, is that right? 20 A. The Patient Rights (Scotland) Act, yes. 21 Q. Patient Rights (Scotland) Act 2001 and that imposes 22 an obligation, you're telling us, on health boards to 23 have a system to deal with individual patient 24 complaints, is that right? 25 A. Correct. Page 23
1 real issue lies within the system that inhibited that 2 individual's ability to be able to deliver the best 3 service they possibly could to a patient. Is that a -- 4 is that something that happens? 5 A. Yes, it can be. There may be issues in relation to 6 staffing. There may be issues in relation to workload. 7 There may be issues in relation to the design of 8 services that can impede that and that's where it's 9 important to understand the pressures or the different 10 context, operating context, in which the system is 11 working. 12 Q. Because if one waits, as you have talked about, for 13 there to be an accumulation of a number of adverse 14 patient experiences before starting to undertake -- and 15 I know your organisation was never asked to undertake 16 a review of any of this, but before starting to 17 undertake a systemic review, for many people if the 18 system is at fault that can be way too late, would that 19 be fair? 20 A. Yes, it can be way too late in terms of their 21 experience. 22 Q. Yes, and so would the concept, at least of more direct 23 contact, be that the services and experience of 24 an organisation like yours could be engaged more quickly 25 such that more direct assistance could be afforded and Page 22	1 Q. And that's one of the patient rights, included within 2 the act, yes? 3 A. Yes. 4 Q. And then, as I understand it, you mentioned the Scottish 5 Public Services Ombudsman. Would it be the case that 6 the individual patient would then have the right, if 7 dissatisfied with the outcome of the complaints process, 8 to go to the Ombudsman, is that right? 9 A. That's correct. 10 Q. And is what you're saying at the moment that Healthcare 11 Improvement Scotland would then tend to liaise with the 12 Ombudsman to work out whether a pattern, as you've 13 described, is emerging from a particular institution or 14 across the system, is that right? 15 A. That's right, and then the sharing intelligence network 16 becomes an important part of that but also we'd say that 17 Scottish Public Services Ombudsman who's recently 18 joined -- I don't know how recent it is, but is a new 19 Ombudsman and has been sharing thinking -- not thinking 20 but in terms of evidence and examples of where there is 21 a pattern in particular boards. 22 Q. You've mentioned -- a couple of times now you've 23 mentioned the importance of intelligence sharing and the 24 network that exists. I think there were two 25 manifestation of the network at different times -- Page 24

1 A. Yes. 2 Q. -- which you explain in detail in your report. However, 3 the body -- we heard a little bit of evidence from the 4 Executive Medical Director of what was NHS Education for 5 Scotland about this network last week and that is 6 a body -- it's now Public Services Delivery Scotland, 7 I think, but that body sits as part of that network, 8 doesn't it? 9 A. Correct. 10 Q. And I understand that effectively Healthcare Improvement 11 Scotland and that body are quite heavily involved in 12 organising that network, is that right? 13 A. We co-chair it. 14 Q. Co-chair it, yes. Are health boards involved in that 15 network? 16 A. No, they're not. 17 Q. Right. And if -- so, in the process that we've 18 described broadly as to how things work, are you relying 19 then on other bodies, for example the Scottish Public 20 Services Ombudsman or perhaps, if it comes through 21 an educational route what was NHS Education for 22 Scotland, in providing you with intelligence about 23 what's going on at the coalface, if you like? 24 A. To some extent, but what we also have within Healthcare 25 Improvement Scotland is a data management and business Page 25	1 administrative boundaries. And the second role is the 2 point of informing Scottish Government policy and 3 ensuring, as far as possible, that that policy reflects 4 the operational reality on the ground. 5 Q. Thank you. You were the chair of the group 6 between April 2023 and April 2025? 7 A. Correct. 8 Q. Does the chairmanship rotate, or how does that work? 9 A. So the chair involves standing for election. So I stood 10 for election as the vice chair, duly elected and took up 11 the role in 2021. Two years in there and then 12 subsequently you become the chair from 2023 to '25. 13 Q. So presumably you've sat on since you've been the Chief 14 Executive of Healthcare Improvement Scotland, is that 15 right? 16 A. Correct. 17 Q. Has the Eljamel saga been discussed on that body at all? 18 A. In my recollection, not so much the detail. What has 19 been discussed is ways in which the health service can 20 be more responsive in relation to concerns of patients, 21 etc. 22 Q. Are the meetings and processes of that body minuted? 23 A. They are. 24 Q. Are they publicly available? 25 A. I don't know if they're publicly available, no, I don't Page 27
1 intelligence team who are ingathering data in relation 2 to our own work, in individual boards, they may also be 3 informed by their own inspections and aspects of 4 improvement programmes around examples of maternal 5 healthcare. So we're not solely reliant on those 6 bodies, we do generally all work ourselves. 7 Q. So intelligence is brought together and discussed within 8 that group, however there are other means by which your 9 organisation can gather intelligence, is that right? 10 A. Correct. 11 Q. One other aspect -- in your statement you tell us that 12 you were the Chair of the NHS Board Chief Executives 13 Group for two years, from April 2023 to April 2025. You 14 tell us that the role supports the collective leadership 15 of the 22 NHS board chief executives in devising 16 cross-organisational responses to national initiatives 17 and informing Scottish Government policy. What is the 18 remit of that group? 19 A. So it doesn't have a statutory remit. It is a group of 20 22, now 21 chief executives, which is intended to do 21 I think two principal things. One is to examine where 22 collectively NHS boards, by working together, can 23 deliver better outcomes. It might be about shared 24 services. It might be in respect of designing services 25 in a different way across current geographical Page 26	1 know. 2 Q. And how often does the body meet? 3 A. The body meets monthly. 4 Q. Do you know -- I have tried this question with a number 5 of other people who haven't known the answer, but do you 6 know what the future of that body and indeed Healthcare 7 Improvement Scotland is under the recently announced 8 arrangements to reformulate the way in which NHS 9 Scotland delivers its services under a reduced number of 10 boards? 11 A. No, I don't. I don't know what -- we await a business 12 case for the future. 13 Q. I see. So there's been a sort of policy announced, but 14 there's going to be a process of working out how that 15 looks in practice? 16 A. Correct. 17 Q. But presumably that would have a significant impact on 18 the group we've just been talking about because I think 19 you mentioned there's now 21 chief executives. 20 Presumably there will be less chief executives under the 21 new arrangements. 22 A. Yes, if you followed its logic there will be two -- two 23 in terms of territorial boards, sorry, but there would 24 be other national boards around that table. 25 Q. Of course. Why is it 21 rather than 22? Page 28

1 A. 21 -- originally, I was including the separation of NHS 2 Education for Scotland and National Services Scotland 3 which is now combined in to be Public Services Delivery 4 Scotland. 5 Q. I see. So those two bodies had two chief executives and 6 now they have one under Public Services Delivery 7 Scotland? 8 A. Correct. 9 Q. It's quite difficult to keep up with the new 10 arrangements but that's helpful. Another thing you told 11 us is -- 12 THE CHAIR: Mr Dawson, I hope I'm not cutting across you and 13 if I am, I'm sure you will ask it in a better way 14 subsequently, but I'll try. I noted some little time 15 ago you making the suggestion that one of the things 16 that the Inquiry might be interested in looking at is, 17 if you like, a more direct connection between patients 18 and patient groups and your organisation -- and you went 19 on to describe various ways in which information is 20 currently gathered and shared and you used the term 21 indeed "intelligence" in the context of that discussion. 22 A. Yes. 23 THE CHAIR: Now, you may not have a particular view, and 24 I wouldn't hold you to one, but the question that does 25 arise in my mind is why it is that, notwithstanding the Page 29	1 A. Correct. 2 Q. And Healthcare Improvement Scotland is not 3 an independent body in the sense that it's part of 4 NHS Scotland, but it is a body which is focused 5 particularly focused on patient safety and care, isn't 6 it? 7 A. Correct. 8 Q. And so whereas a health board might have a multitude of 9 considerations to take into account, matters of 10 practicality etc, if Healthcare Improvement Scotland 11 were involved at a slightly earlier stage, it would be 12 a patient safety, patient care focus in its involvement, 13 would it not? 14 A. Do you mean Healthcare Improvement Scotland or the 15 board? 16 Q. I mean Healthcare Improvement Scotland. 17 A. Yes, absolutely. One thing I would put as a caveat to 18 that is boards are not absolved of their 19 responsibilities in relation to safety. They have 20 a legal duty for quality under -- I think it's 21 section 12 of the 1978 Act and that was reinforced and 22 introduced on the back of the Bristol Inquiry. 23 Q. Indeed but it's part of the role of Healthcare 24 Improvement Scotland, is it not, to reinforce that duty? 25 A. Correct. Page 31
1 description of the existing processes, you think it 2 would be of interest to the Inquiry to have a look at 3 that connection that doesn't currently exist and whether 4 it reflects, in any way, some deficiency in the 5 arrangements that you have just described? 6 A. Yes, if I may, sir, I think it's coming back to the 7 central point about how do we understand patterns at 8 an earlier point and how do those patterns, whether they 9 relate to professionalism, public concerns, safety 10 concerns, come together to give the truth, or a version 11 of the truth if I could describe that. And therefore we 12 have a current system which works on the basis of 13 complaints being an important part of that and 14 understand that in terms of the complaints procedures in 15 and handling within individual boards but how do we 16 ensure that that rounded picture is fully understood and 17 is visible to everybody and to ultimately to protect 18 patients. 19 THE CHAIR: All right, thank you. Thank you. 20 MR DAWSON: Just to explore a little bit more about that 21 helpful observation, Mr Pearson. The position at the 22 moment, as I think you've explained, would be that if 23 individual patients or groups of patients had an issue, 24 the system would be to go directly to the health board 25 concerned, is that right? Page 30	1 Q. And often in circumstances where a complaint or concern 2 or issue is being raised about quality of care, the 3 complaint involves a complaint being addressed against 4 the board itself, is that not right? 5 A. That's correct. 6 Q. And, as we say, although Healthcare Improvement Scotland 7 is not an independent body it definitely is not the body 8 being criticised in those circumstances? 9 A. That's correct, yes. 10 Q. So it would be able to exercise, to an extent, 11 an independent judgment on matters? 12 A. So if in relation to the service, the quality of the 13 service certainly. What Healthcare Improvement Scotland 14 doesn't do, as outlined, is get into the individual 15 complaints themselves. 16 Q. Indeed, but insofar as those individual complaints gave 17 rise to concerns which were systemic in nature and 18 therefore did fall within your remit, you would be able 19 to look at it with, to an extent, an independent eye on 20 the matter; is that correct? 21 A. That's correct. 22 Q. And also you would be able to look at it with healthcare 23 improvement and patient safety and care at the forefront 24 of your mind because that's really what your 25 organisation is all about? Page 32

1 A. Correct. 2 Q. Could I ask you some questions -- you very helpfully, in 3 your statement, tried to provide as much information as 4 you can about the predecessor bodies of Healthcare 5 Improvement Scotland but we understand that there will 6 be limitations on what you can tell us. But there were, 7 I think, two relevant bodies, is that right, for the 8 period that we're looking at from 1995 to 2015? 9 A. Correct. 10 Q. And the first was the Clinical Standards Board, is that 11 right? 12 A. That's correct. 13 Q. And the Clinical Standards Board existed between 1999 14 and 2003? 15 A. Correct. 16 Q. We had a discussion already about the emergence of 17 clinical governance as, perhaps, an important concept 18 arising out of Bristol and other places in the late 19 '90s, is that right? 20 A. That's right. 21 Q. And was the Clinical Standards Board and its creation 22 part of that, I don't want to say revolution, but 23 development within the system? 24 A. Yes, it was and I think it fell out of the then 25 administration in 1997 produced "Designed to Care" and Page 33	1 organisation does now and that or is that just a phrase 2 which can encompass a lot of different activities? 3 A. I feel there's a considerable road been travelled and 4 difference between what it was in that period of time of 5 the Clinical Standards Board and Healthcare Improvement 6 Scotland today and a number of aspects of that I can 7 elaborate on. 8 Q. Yes, thank you. Just one aspect that I understand 9 exists is that that was a special health board, I think, 10 is that right? 11 A. That's correct. 12 Q. As was its successor? 13 A. That's correct. 14 Q. But Healthcare Improvement Scotland is not a special 15 health board, is that right? 16 A. That's correct. 17 Q. Is there any particular significance in that in terms of 18 the way things operate or is that just an administrative 19 decision? 20 A. So, I wasn't familiar necessarily with the drafting of 21 the policy or the legislation at that point in time but 22 in being a health body, as opposed to a special health 23 board, they were seeking to ensure Healthcare 24 Improvement Scotland had an independence from Scottish 25 Government, that hitherto wasn't as explicit in relation Page 35
1 the intention was to build on systems of clinical 2 governance and the clinical standards board was part of 3 that. 4 Q. You provide in your statement, and indeed in the opening 5 statement provided helpfully to the Inquiry by your 6 organisation, a broad description of what the remit of 7 that body was. Its focus appears to have been on 8 promoting public confidence, that the service provided 9 by the NHS were safe and that they met nationally agreed 10 standards. What was your understanding of that focus on 11 the promotion of public confidence and to what extent 12 has that, over time, been eroded or watered down in what 13 Healthcare Improvement Scotland does now? 14 A. So in establishing the Clinical Standards Board what was 15 intended to do was to understand the quality of care 16 across Scotland based on standards which developed 17 within the Clinical Standards Board. And what they 18 would carry out against particular standards may be in 19 relation to heart disease, peer review of NHS boards 20 against those standards, and it would be a rolling 21 programme and individual reports we published 22 and an overview on that particular standard for NHS 23 Scotland. 24 Q. But given this focus on promoting public confidence, is 25 there a significant difference between what your Page 34	1 to the specific health board status of the predecessor 2 bodies, I think that was what was going on. 3 Particularly in response to what was a review carried 4 out by Lorne Crerar in formulating the subsequent 5 legislation that set up Healthcare Improvement Scotland. 6 Q. I see, so we'll got to the body in between in a moment, 7 but at the time when Healthcare Improvement Scotland was 8 set up in 2011, one of the things that was part of the 9 driver for the new body to be created was the need for 10 the body to be more independent from the rest of the NHS 11 and Scottish Government, is that right? 12 A. That's correct. 13 Q. And it was thought that a way of trying to achieve that 14 would be to stop the bodies that existed before, or the 15 body that existed before, being a special health board 16 which meant automatically it was part of the NHS, if you 17 like? 18 A. My understanding is that was the driver, yes. 19 Q. Okay. Another aspect of the remit of the Clinical 20 Standards Board which you've helpfully set out for us is 21 its remit included demonstrating that the NHS was 22 delivering the highest possible standards of care based 23 on the resources available. Now, again, the focus on 24 the limitation being based on the resources available, 25 I think later in your statement you talk about a role Page 36

1 that Healthcare Improvement Scotland has within certain 2 staffing rules, I think. And how has that aspect of 3 things changed between the Clinical Standards Board and 4 what your organisation delivers now? 5 A. Yes, so a number of changes have happened over that 6 time. I think the first thing I would say in relation 7 to the inspections is there is a much stronger approach 8 in relation to expectations and holding to account. We 9 don't just produce recommendations, we produce 10 requirements against standards and we pursue those 11 vigorously. Coming back to your point in relation to 12 the safe staffing, the safe staffing legislation was 13 enacted in 2024, I think, and sets expectations in 14 relation to safe staffing in the system and we use 15 a number of tools to understand that to provide a common 16 staffing method which is about professional judgment, 17 but also tools that allow individual wards to understand 18 what would a staffing need to be in the context of 19 patient mix, for instance. 20 Q. Because if, as appears to have been the case for the 21 Clinical Standards Board, the obligation is to promote 22 healthcare improvement but within quite fixed resourcing 23 parameters, it excludes, does it not, the possibility 24 that the staffing could be the problem in terms of the 25 quality of healthcare that's advanced, is that right? Page 37	1 A. Correct. 2 Q. Would that be correct? 3 A. Yes, that's correct. 4 Q. You mentioned -- there's an aspect that you've touched 5 upon there I was going to come back to, but I'll just 6 dwell on now in the context of these historic 7 organisations. You mentioned there that part of the 8 Healthcare Improvement Scotland's remit is to undertake 9 inspections; is that correct? 10 A. Correct. 11 Q. We'll look at that in a bit more detail but one of the 12 results of those inspections could be that it creates 13 and promulgates requirements against standards, I think 14 you said, yes? 15 A. Correct. 16 Q. And I think you said that your organisation would pursue 17 them vigorously, is that right? 18 A. Yes. 19 Q. Healthcare Improvement Scotland is, however, for the 20 NHS, not a regulator of healthcare services; is that 21 correct? 22 A. That's correct. 23 Q. So therefore although you can undertake inspections, 24 yes? 25 A. Yes. Page 39
1 A. I'm choosing my words carefully about what decisions or 2 what judgments were made at that point in time, but the 3 position today, if I could describe it, is we work on 4 the basis that there are choices to be made in a policy 5 sense about where you resource and how much resource 6 goes in but that doesn't detract us from commenting when 7 services are unsafe, whether it's in staffing or matters 8 of infection control. 9 Q. But without getting into any particular decisions of the 10 Clinical Standards Board or the way it went about doing 11 things, just in terms of the remit, if you are looking 12 at the safety within the parameters of the resources 13 available then it excludes, does it not, the possibility 14 that you could say: well, the problem here is that there 15 isn't enough staff to deliver the service to the level 16 that it should be delivered, is that right? 17 A. Yes. 18 Q. I think the position, just to tease out a little bit 19 more about the new healthcare staffing legislation from 20 2024 that you've referred to, your organisation now 21 would be, through that legislation and other enabling 22 measures, able, if it were inspecting or looking at 23 a particular health service to say: well, that health 24 service is not performing adequately because it doesn't 25 have enough staff, is that right? Page 38	1 Q. And you can, at the end of the day, come up with 2 detailed requirements against standards, is that right? 3 A. Yes. 4 Q. And you can, as you say, pursue them vigorously, is that 5 right? 6 A. Yes. 7 Q. There is a limitation as regards what you can do by way 8 of enforcement; is that correct? 9 A. There is but if I may elaborate in relation to how it 10 works? 11 Q. Yes, please. 12 A. Without straying too far, the compare and contrast has 13 been between what NHS Scotland has versus, for instance, 14 England. Looking on that system, we've been used to 15 thinking about the National Health Service being 16 a single homogeneous entity. It's not and 17 post-devolution, there were different paths chosen at 18 that point in time for England. England chose to adopt 19 I suppose a lighter touch from the centre, autonomous 20 NHS foundation trusts that would be regulated in 21 relation to licensing, but also in relation to the 22 quality and safety of care through, ultimately, the Care 23 Quality Commission. 24 Q. Sorry to interrupt, but if we just take that carefully 25 because there's lots of concepts in there and bodies. Page 40

1 So you're helpfully comparing and contrasting the 2 post-devolution period and the way that the NHS in 3 Scotland has chosen to organise itself, or the way 4 Scottish Government has chosen to organise it and you're 5 contrasting that with the way it works in England. So 6 in England, what you've told us, I think, is that the 7 model involves having NHS trusts; is that correct? 8 A. Correct, foundation trusts. 9 Q. Foundation trusts, and the foundation trusts deliver the 10 healthcare services, is that right, within the NHS? 11 A. Yes. 12 Q. And I think you've said something about them having 13 certain responsibilities in that regard, is that right? 14 A. Yes. 15 Q. And to whom do they have those responsibilities? 16 A. So when they were originally set up, the responsibility 17 was to two bodies. One was monitor, which was the 18 economic licensing regulatory body, if that's the right 19 way to describe it, and the second was to what was then 20 the Healthcare Commission and subsequently became CQC. 21 And they were doing two things: one was the economic and 22 financial regime, if that's the right way to describe 23 it. And the second one was around patient and safety 24 regulation, through the other body called -- originally 25 Healthcare Commission, subsequently CQC. Page 41	1 a health board, we then can escalate, through the 2 operating framework, those concerns to Scottish 3 Government. Originally to the health board perhaps, if 4 they don't make the necessary changes, to Scottish 5 Government. And in extremis, the chair of Healthcare 6 Improvement Scotland can go directly to the cabinet 7 secretary. 8 Q. So in a sense would it be correct to say that the 9 cabinet secretary is the regulator, or the directorate 10 for health and social care is the regulator for NHS 11 healthcare providers in Scotland? 12 A. That would be a way of characterising it which I could 13 recognise that under the direction the range of 14 interventions in that ladder of intervention from -- and 15 it goes from 1 to 5, ultimately ministers have the power 16 to intervene directly into the health board. 17 Q. Yes. So when you say "1 to 5", is that a scale of 18 recognition? 19 A. That's a scale of where boards sit in relation to levels 20 of concern around -- it might be around finance, it 21 might be around leadership and governance. And that's 22 a graded scale of intervention by Scottish Ministers. 23 Q. And is Healthcare Improvement Scotland responsible for 24 investigating and setting that scale or is that done by 25 government? Page 43
1 Q. And CQC is the Care Quality Commission and that is, in 2 effect, a regulator for the healthcare provided by the 3 trusts, is that right? 4 A. Yes. 5 Q. And that function is not undertaken in Scotland by 6 Healthcare Improvement Scotland, is that right? 7 A. Correct, that's not undertaken. 8 Q. Although we'll get into the detail of it, it does do 9 certain things to promote healthcare but it is not 10 a regulator in the same way? 11 A. Correct. 12 Q. In what ways does its efforts to try to improve 13 healthcare in Scotland differ from the Care Quality 14 Commission's powers and remit? 15 A. So the CQC will have the powers, which are similar to 16 our powers as an independent regulator of the 17 independent sector, in relation to licensing, 18 improvement notices, curtailment of services and other 19 sanctions within that. The difference then becomes how 20 Healthcare Improvement Scotland acts within the context 21 of the broad position and infrastructure and 22 architecture of the NHS in Scotland, where boards are 23 essentially under the direction of Scottish Ministers. 24 And when we have serious and sustained concerns about 25 a particular health board or a particular service within Page 42	1 A. That's done by government. 2 Q. Right, but you might be -- your organisation might be 3 involved in investigating and assisting the conclusions 4 being reached as to where someone would sit in that 5 scale, is that right? 6 A. Yes, so what we would do is we would have a -- if we had 7 a serious concern about a particular service we would 8 escalate that to Scottish Government. Scottish 9 Government would then make a decision itself based on 10 a number of factors as to where it placed that board on 11 the escalation ladder. 12 Q. You mentioned there the independent sector. 13 A. Yes. 14 Q. Does that mean the private providers of healthcare? 15 A. Yes. Correct. 16 Q. And your organisation has a different role in respect of 17 those particular healthcare providers, doesn't it? 18 A. We do, we're a regulator of those services. 19 Q. So you're involved, I think you told us, in licensing 20 those services, is that right? 21 A. Yes, registration. 22 Q. And you could issue, I think you said, improvement 23 notices, is that right? 24 A. Correct. 25 Q. Which would involve circumstances in which you had found Page 44

1 that something was going wrong and you issued a notice 2 saying: these are the ways in which we require you to 3 improve your service; is that correct? 4 A. Correct. 5 Q. And ultimately, if those notices were not complied with 6 or in other circumstances, you could remove the 7 registration? 8 A. Correct. 9 Q. Or you could curtail the independent healthcare 10 provider's ability to provide services? 11 A. Correct. 12 Q. And so for example, could -- that would involve cover, 13 for example, private hospitals, would it? 14 A. Yes. 15 Q. And so if completely hypothetically, if you were to find 16 for example that a particular medical service being 17 offered within a private hospital was giving rise to 18 a particular concern, you would investigate in the first 19 instance, would you? 20 A. Correct. 21 Q. And the basis for the investigation would be through the 22 various intelligence mechanisms that you've described 23 already, is that right? 24 A. Yes. I would say when it comes to the independent 25 sector, the nature of it as a regulated sector is Page 45	1 set out in a schedule in relation to premises, about 2 record-keeping, and that's underpinned very directly 3 with legislation. 4 Q. So the requirements both for those bodies and the role 5 of Healthcare Improvement Scotland in enforcing those 6 standards are much more particular, I think, is that 7 right? 8 A. I wouldn't say they -- we use the same quality assurance 9 framework in relation to standards around healthcare and 10 other aspects of our quality assurance framework and the 11 various domains within that and leadership and 12 governance, but there's a particular set of requirements 13 in the 2011 regulations about -- that are explicit about 14 record-keeping, staffing, that we then have the powers 15 in which to then exercise enforcement notices on. 16 Q. Understood. Thank you for all that. We'll jump back to 17 our historical analysis now. We were talking about the 18 Clinical Standards Board and we know that that ceased to 19 be in I think 2003, is that right? 20 A. That's correct. 21 Q. And then another body came into being called NHS Quality 22 Improvement Scotland, is that right? 23 A. That's correct. 24 Q. And that was the body which -- it was in place from 2003 25 to 2011? Page 47
1 chiefly through the work of Healthcare Improvement 2 Scotland. So the work of, as I said, the sharing 3 intelligence group and the sharing intelligence network 4 has been about principally for health and care within 5 the state system, if that's the right way to describe 6 it. 7 Q. Does that mean therefore that there is a more regulated 8 systemic system of, say, inspection of those types of 9 bodies when compared with the NHS? 10 A. I wouldn't say that the system was more systemic. We 11 are robust when it comes to the NHS. The powers that 12 sit behind us in relation to the independent sector are 13 very different in relation to our sanctions and ability 14 to pursue directly those organisations if they are 15 failing. 16 Q. I see. So if you take, for example your hypothetical 17 private hospital verses your hypothetical NHS hospital, 18 would there be a system that -- you described all the 19 various things that you would have to do within the 20 private system. In the private system, would you do 21 regular inspections? 22 A. Yes. So we do regular inspections in those services and 23 we follow up in relation to requirements within that. 24 And the other point I would say in relation to 25 independent sector is a number of those requirements are Page 46	1 A. Correct. 2 Q. And it therefore was the immediate predecessor, if you 3 like, in broad terms of Healthcare Improvement Scotland? 4 A. Yes. 5 Q. And again, you've helpfully provided, both in your 6 statement and in your opening statement, some of the 7 functions that -- you mention, I think, there were six 8 key functions of that organisation. And I'm just 9 interested in knowing which of these functions have 10 continued into Healthcare Improvement Scotland and which 11 have not, to the extent they have or have not. One of 12 them was providing advice and guidance on effective 13 clinical practice. Is that something Healthcare 14 Improvement Scotland does now? 15 A. Yes, we do and we do it in relation to setting standards 16 or it might in relation to guidelines but it also covers 17 aspects of the clinical and cost-effectiveness of new 18 medicines, for instance. 19 Q. I see. So in the sense you are providing guidance on 20 clinical practice not to individual doctors or anything 21 like that but in the broad sense, you have the power to 22 provide guidance and set standards for the clinical 23 aspects of the healthcare provision, is that right? 24 A. Correct. 25 Q. And one of the other standards -- the second standard is Page 48

1 setting clinical and non-clinical standards of care. 2 What would non-clinical standards of care cover? 3 A. So the non-clinical would be in relation to aspects of 4 leadership, governance in the system and expectations 5 about, I guess, tone from the top, if that's the right 6 phrase to use. 7 Q. You mention in your statement -- I think, when you 8 mention leadership and coming from the top, I think you 9 say in your statement that those really the focus of 10 Healthcare Improvement Scotland's monitoring and 11 assessment, if you like; it looks at that top level. Is 12 that correct that that's the approach that you take? 13 A. So we don't take that approach exclusively. So we're 14 looking at the quality and safety of care from the front 15 line, whether it be in a maternity unit, all the way 16 through to the extent to which the leadership and 17 governance of this organisation is open, transparent and 18 accountable. 19 Q. The third of the principles or functions was reviewing 20 and monitoring NHS services which you've already told us 21 Healthcare Improvement Scotland does, is that right? 22 A. Correct. 23 Q. Supporting staff in improving services, is that 24 something that you do? 25 A. Yeah, so we do a number of things in that regard across Page 49	1 your organisation has, but what is the approach of 2 Healthcare Improvement Scotland to that diverse and 3 complex area, say for example, in a large hospital? 4 A. Yeah. So in our quality assurance framework we have 5 a number of broad headings and a number of domains. And 6 within those domains it includes involving staff, it 7 involves the extent to which it involves the public, but 8 it also includes governance and ensuring there are 9 robust governance. And robust governance includes 10 clinical governance within that and that's where we 11 cover aspects of that and apply it through, for 12 instance, the lens of the health and care standards or 13 it might in relation to infection prevention and 14 control. 15 Q. Because, as we touched on before, it is perhaps rarely 16 through immediate concerns about clinical governance 17 systems that issues which might ultimately result in 18 there being issues with the clinical governance systems 19 might come to light. Would it be fair to say that one 20 requires to have a regular programme of assessment of 21 clinical governance to work out whether it is 22 functioning adequately or not? 23 A. So I think this becomes then a test of the balance 24 between the responsibilities of individual boards to 25 meet their obligations to ensure robust, sound clinical Page 51
1 our improvement work around the Scottish safety 2 programme, in relation to the contribution of staff to 3 ensuring their staffing tools are up to date and reflect 4 clinical practice and the workload on the ward. So it 5 happens in a whole host of ways in which we engage with 6 the service to help and support improvement. 7 Q. We'll come back on to something called the "SIGN 8 guidelines" in a moment which may impact upon that. The 9 fifth of the functions was the promotion of patient 10 safety which you've told us your organisation does, is 11 that right? 12 A. Correct. 13 Q. And is there a difference between patient safety and 14 patient care? 15 A. So patient care would be the entirety of the care 16 delivered from arrival in hospital to discharge. 17 Patient safety is an important dimension of that, 18 ensuring that care is up to date, reflects best practice 19 and reflects the very best standards. 20 Q. And the final of the functions was the implementation of 21 clinical governance, does Healthcare Improvement 22 Scotland do that? 23 A. Yes, we do. 24 Q. As far as the implementation of clinical governance is 25 concerned, you mentioned already various powers that Page 50	1 governance each and every day and they may uphold their 2 duties within the legislation, but frankly, it's not 3 about the legislation, it's about keeping patients safe. 4 And then where do external bodies fit into that, 5 like Healthcare Improvement Scotland, to test from time 6 to time through the lens of individual services like 7 maternity or the care of older people, as to whether 8 that is actually being met in practice. In other words, 9 closing the inside gap between where a board thinks it's 10 at and the reality by an external inspection. But it's 11 trying to get away from the point that we're all waiting 12 for an inspection as opposed to doing the job each and 13 every day about ensuring robust clinical guidance exists 14 between the organisation. 15 Q. So there's a balance to be struck there? 16 A. It's a balance. 17 Q. To take a non-hypothetical example, we've heard quite 18 a bit of evidence, both through the evidence of the 19 Chief Executive of NHS Tayside and through evidence 20 we've heard from patients -- this is dealing with the 21 current position but also historically -- of there being 22 numerous issues with NHS Tayside's document management, 23 if one might put it as broadly as that. There are 24 considerable bodies of evidence of people not being able 25 to access medical records, having issues with there Page 52

1 being missing medical records. There are several 2 instances where people have complained about data 3 breaches relating to confidential information. And we 4 looked last week at a recent decision of the Scottish 5 Information Commissioner relating to failings in 6 document management within NHS Tayside. My 7 understanding is that Healthcare Improvement Scotland 8 hasn't, to date, involved itself in any of those 9 matters; is that correct? 10 A. That's correct. 11 Q. Would it be possible for Healthcare Improvement Scotland 12 to seek, given that evidence -- which I've put broadly 13 and of course a lot more specifics -- to seek to 14 investigate the issues that exist within the document 15 management systems, hypothetically, based on that broad 16 evidence base? 17 A. So in relation to our role, ultimately it's about 18 patient safety, and there are a whole series of systems 19 and processes within that. So hypothetically, yes, 20 Healthcare Improvement Scotland could do that in the 21 context of governance, and ensuring that safe systems 22 existed in relation to leadership and all the parts are 23 in there. 24 Q. But just to understand that in the context of the 25 balance you were talking about a moment ago. In order Page 53	1 become involved in looking at an issue like that? 2 A. No, I don't there has been an extreme situation. We 3 have got sufficient independence and powers to go where 4 we need to go as an organisation and I think part of the 5 evolution, when I say of this, of Healthcare Improvement 6 Scotland as an independent, nobody is saying to me: look 7 over there and not look over there. And certainly for 8 a number of boards in the past two or three years, it's 9 by our own volition and only ability to act as 10 an independent body, we've gone there and done the work. 11 Q. Thank you. I want to ask you about that as well based 12 on what you've said. In those circumstances, in that 13 type of situation, you're telling me therefore that you 14 wouldn't rely -- you mentioned a moment ago the need to 15 make sure that Scottish Ministers have their 16 responsibilities, and Healthcare Improvement Scotland 17 has its responsibilities. You wouldn't be dependent on 18 the Scottish Ministers telling you to go and 19 investigate, you could do that of your own volition, is 20 that right? 21 A. Absolutely. 22 Q. And are there circumstances in which you have done that 23 in recent years? 24 A. Yes, we are currently spending -- and we have spent time 25 in NHS Lothian in relation to maternity services based Page 55
1 to decide to do that, which you could do theoretically, 2 you would need to be persuaded that that would be 3 a responsible use of the resources and the systems 4 available to you because effectively that would take 5 attention away from, I think you called it the sort of 6 the day-to-day improvement of patient safety, which 7 you're doing all the time; is that correct? 8 A. I think everything is a matter of prioritisation within 9 the resources of Healthcare Improvement Scotland but the 10 second thing is to avoid duplication between other 11 agencies and Scottish Government in relation to its role 12 and it probably comes back to the generally point about 13 health boards being under the direction of Scottish 14 Ministers about what is their interventions in these 15 moments, versus the role of the Healthcare Improvement 16 Scotland. But everything is about weighing up and 17 a balance across our role and responsibilities about 18 where we become involved. 19 Q. Okay, so would it be fair to say because of those 20 important day-to-day patient safety responsibilities 21 that you've talked about and the obvious need to strike 22 a balance within your resources, that intervention in 23 a situation like that would only happen in very extreme 24 circumstances? It would only be in extreme 25 circumstances that it would be justified for you to Page 54	1 on signals about the quality and safety of care and we 2 have done that. 3 Q. Was that of your own volition, if you like? 4 A. Own volition, absolutely, and based on intelligence we 5 received. And similarly, we have ultimately been 6 invited into NHS Grampian to do work on matters of 7 clinical governance, but it's fair to say that was on 8 the basis of a range of concerns. 9 MR DAWSON: Thank you. Sir, that would be a convenient 10 moment for a break, if that's suitable. 11 THE CHAIR: We're going to take a 15-minute break. 12 Mr Pearson, to keep matters regular we do ask witnesses 13 not to discuss their evidence when we break during the 14 day, but we'll aim to start again at half past, thank 15 you. 16 (11.14 am) 17 (A short break) 18 (11.31 am) 19 THE CHAIR: Thank you, Mr Pearson. We're ready to resume. 20 MR DAWSON: Thank you, sir. Mr Pearson, we're going on to 21 a subject that I mentioned in passing but we haven't 22 touched on in any detail yet, that's the 23 SIGN guidelines. Could we go to the statement, please, 24 HIS-00047 at paragraph 3.26, which is at page 8. 25 This was in the context of you telling us something Page 56

1 about the historic organisations and clarifying aspects 2 which had carried on from the previous body into the 3 Healthcare Improvement Scotland's functions and you 4 mention, at paragraph 3.26.1, a little further down, the 5 Scottish Intercollegiate Guidelines Network, where you 6 say: 7 "The Scottish Intercollegiate Guidelines Network 8 (SIGN) became part of NHS QIS in 2005. SIGN was 9 established in 1993 by the Academy of Royal Colleges and 10 their Faculties in Scotland, to develop evidence-based 11 clinical guidelines for the NHS in Scotland. The 12 membership of SIGN includes all the medical specialties, 13 nursing, pharmacy, dentistry, professions allied to 14 medicine, patients, health service managers, social 15 services, and researchers. Under the transfer agreement 16 with the Academy and NHS QIS, SIGN retained editorial 17 independence in relation to the guidelines it produced. 18 All SIGN staff are employed by Healthcare Improvement 19 Scotland (formerly NHS QIS), and the SIGN programme is 20 supported by core funding from Healthcare Improvement 21 Scotland and the SIGN team are part of the Evidence and 22 Digital Directorate of HIS ..." 23 So that's a kind of potted history what the 24 SIGN guidelines are and how the various different 25 organisations are involved. Can you just clarify for Page 57	1 a transfer agreement with the academy and NHS QIS, which 2 was the predecessor body to your organisation, and so 3 was there some extent to which, at that point, NHS QIS 4 became involved in the production of the 5 SIGN guidelines? 6 A. Yes, so in that transfer the accountability then rested 7 with NHS Quality Improvement Scotland. 8 Q. So did the colleges that you mentioned and the academy 9 continue to have an involvement? 10 A. So they have involvement around a body called 11 SIGN council that sits, that has oversight of the 12 development of the guidelines and prioritisation of 13 those guidelines and representation from those Royal 14 Colleges sits on the SIGN council. 15 Q. And so there was mention there of SIGN retaining 16 editorial independence in relation to the guidelines it 17 produced. When you refer to "SIGN" SIGN there, does that 18 mean the council or what does that mean? 19 A. Yes, so this is an interesting point, if I may just 20 develop this. In relation to things moving into NHS 21 Quality Improvement Scotland, there's was -- the best 22 way I can describe it is a hosting of those entities 23 within NHS Quality Improvement Scotland. So the 24 Healthcare Environment Inspectorate was hosted from 25 2009-ish, SIGN was hosted. And they were largely Page 59
1 us -- there's a history of these guidelines which are 2 clinical guidelines going back, I think, to 1993, is 3 that right? 4 A. That's correct. 5 Q. And you mentioned there that there was involvement at 6 some stage by something called the Academy of Royal 7 Colleges and their faculties in Scotland; what are those 8 organisations? 9 A. So the Academy of Royal Colleges is the overarching 10 umbrella organisation that hosts and convenes the Royal 11 College of Surgeons/Physicians and it has a chair of 12 that academy as well as individual presidents of those 13 Royal Colleges. 14 Q. Right, so that's all the Royal Colleges of different 15 medical disciplines? 16 A. Medical Royal Colleges. 17 Q. Yes, so for example, we've heard some evidence from the 18 Royal College of Surgeons of Edinburgh. That would be 19 one of the colleges? 20 A. Correct. 21 Q. And it was the position, since 1993 I think, that 22 effectively that body of Royal Colleges produced 23 clinical guidelines, is that right? 24 A. That's correct. 25 Q. And then at some stage you mention there had being Page 58	1 semi-autonomous entities within NHS Quality Improvement 2 Scotland. So in there, that's a reference to that, that 3 there was a degree of independence within NHS Quality 4 Improvement Scotland, which has now subsequently changed 5 with the integration of a number of those elements that 6 were, as I say, hosted with NHS Quality Improvement 7 Scotland as they have evolved into Healthcare 8 Improvement Scotland. 9 Q. Okay, so at the time when we're dealing with Quality 10 Improvement Scotland, SIGN already existed before that, 11 is that right? 12 A. Yes. 13 Q. But it didn't have a home, if you like, within the 14 system; is that correct? 15 A. That's correct. 16 Q. And so effectively, the colleges had what one might 17 describe as editorial independence over the guidelines, 18 is that right? 19 A. Yes, yes. 20 Q. But they were housed, from an administrative 21 perspective, within the new QIS body, is that right? 22 A. That would be a fair way of describing it. 23 Q. But it's important, I would imagine, to the colleges 24 that they were the ones who still decided what went into 25 the guidelines, because they were the experts in the Page 60

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1 individual clinical fields? 2 A. Yeah, and importance about ownership and a credibility 3 of those guidelines to the service. 4 Q. And as far as the transition of that system into 5 Healthcare Improvement Scotland is concerned, how does 6 that work in terms of the editorial independence to the 7 colleges and are the colleges still involved? 8 A. Yes, still involved and the important part, as I say, of 9 SIGN council and important point about the credibility 10 of this work, that it has an ownership and that clinical 11 ownership of those colleges and experts in helping to 12 frame those guidelines. 13 Q. So is it still the case that the Academy of Colleges has 14 the editorial control over their content? 15 A. No, if I maybe can be clear. The SIGN council has 16 accountability now for the quality and the discharging 17 of that, through director of evidence in digital, who is 18 accountable me as a member of the executive team. She 19 assures herself in that there's a robust methodology, 20 there's close engagement of clinicians in that, but in 21 relation to the pieces of evidence that Healthcare 22 Improvement Scotland generate, SIGN, Scottish Medicines 23 Consortium, we depend on robust methodology and that 24 accountable come backs to me as Chief Executive, 25 ultimately. Page 61	1 integration and accountability and clarity of that. 2 Q. So that made the corporate structures around these 3 previously relatively autonomous bodies more robust; 4 would that be correct? 5 A. It would be more robust, it would be about ensuring 6 an alignment of, as far as possible, priorities to the 7 whole organisation and an increasing importance on the 8 integration of our work. Because the things that 9 confront of system in relation to healthcare challenges 10 are not for one bit of system inspection alone or 11 improvement. It's about the blend of functions within 12 Healthcare Improvement Scotland, how we deploy that in 13 a more integrated way. 14 Q. Thank you and we've also seen, in some of the paperwork, 15 something called the NICE guidelines. 16 A. Yes. 17 Q. Those are produced by the National Institute for 18 Clinical Excellence, as I understand it? 19 A. Correct. 20 Q. Are they similar to the SIGN guidelines? 21 A. They are similar and they also have appropriate 22 collaboration at times in relation to -- between SIGN 23 and NICE in relation to asthma, for instance in the UK 24 guidelines, but it's a separate body in England. 25 Q. In terms of that corporate robustness and Page 63
1 Q. I see, but there's still an important clinical input by 2 the colleges through the council? 3 A. Yes. 4 Q. One of the things that you mentioned in the statement on 5 a number of occasions when talking about the transition 6 and creation of Healthcare Improvement Scotland is, 7 I think, there's accountability through the chief 8 executive as a concept. I think that was an innovation 9 of Healthcare Improvement Scotland from the statement. 10 Is that correct and can you explain what you mean by 11 that? 12 A. Yes, so if you go back to NHS Quality Improvement 13 Scotland and maybe just do a bit of compare and 14 contrast, it absorbed a number of entities in its 15 establishment in 2003. And to some extent, elements 16 within it were fully autonomous, such as the Scottish 17 Health Council, to some extent the Scottish Medicines 18 Consortium. And as we moved into Healthcare Improvement 19 Scotland in the establishment of the new body, there was 20 a much stronger alignment of the accountability through 21 directors and to the chief executive because ultimately 22 in relation to the establishment of Healthcare 23 Improvement Scotland as a health body, the 24 accountability had to be exercised in an appropriate 25 way. And that then became an important part of the Page 62	1 accountability, why is it deemed important that Scotland 2 has its own system of production of these clinical 3 guidelines, as opposed to relying on, say, the NICE 4 guidelines? 5 A. It's important in relation to the context of the 6 Scottish population, in relation to the models of 7 service delivery. 8 THE CHAIR: What do you mean the context of the Scottish 9 population? 10 A. Yeah, in relation to aspects of morbidity, related -- 11 and the profile of certain diseases etc and also the 12 health status of Scotland. So there's an opportunity to 13 ensure that those guidelines are sensitive to a Scottish 14 context I think has been important in the evolution of 15 it. 16 THE CHAIR: Thank you. 17 MR DAWSON: Thank you. I'd just like to ask you a couple of 18 questions about another aspect of the work of Healthcare 19 Improvement Scotland that you cover in your statement 20 which I think was, again inherited if you like, from the 21 previous body, which is to do with your role in 22 monitoring medical evaluation and appraisal. You, 23 I think -- please correct me if I'm getting this wrong, 24 but there was an ongoing role that the predecessor body, 25 QIS, had in monitoring the medical revalidation and Page 64

1 appraisal system within Scotland, is that right? 2 A. So it would really be at the point of Healthcare 3 Improvement Scotland -- this is just testing my 4 recall -- in relation to when the appraisal and 5 revalidation system came into being. And -- 6 Q. It might be helpful just to look at the statement where 7 you give the details. It's paragraph 10.8 at page 18. 8 Could you just tell us, before we get to that, what is 9 medical revalidation and appraisal? 10 A. Yes. So medical revalidation and appraisal was 11 introduced in relation to ensuring doctors were -- their 12 fitness to practice and they were up to date in relation 13 to the clinical skills by annual appraisal and in 14 a five-year cycle of revalidation and the responsible 15 officer and individual boards making a recommendation to 16 the General Medical Council. 17 Q. Yes, I think what we've heard before is that this was 18 a requirement that came in at a certain point by the 19 GMC, is that right? 20 A. Yes. 21 Q. In relation to individual doctors, is that right? 22 A. Yes. 23 Q. But of course, individual doctors is not the realm of 24 Healthcare Improvement Scotland, isn't that right? 25 A. Correct. Page 65	1 in respect of the training environment of resident 2 doctors (formerly junior directors) ..." 3 And you talk about the sharing mechanisms that we've 4 talked about already. Could we please have a look at 5 HIS-00011. Just one second, Mr Pearson. (Pause). 6 MR DAWSON: Sorry, there's an issue with getting access to 7 this quite important document, so if we could have 8 five minutes? 9 THE CHAIR: Yes, we'll break for five minutes, everybody. 10 Mr Pearson, I'll ask you to go back to the witness room 11 for a few minutes and we'll sort the problem out. 12 (11.45 am) 13 (A short break) 14 (11.51 am) 15 MR DAWSON: Thank you, sir. Sorry about that, Mr Pearson. 16 Just getting the document up, it's HIS-00011, if we 17 could just look at the opening page, first of all. This 18 is a document you helpfully provided to us, which is 19 a document dated October 2013, it's entitled "From 20 readiness to revalidation: a report on medical 21 revalidation progress in 2012-13". Is this the report 22 that Healthcare Improvement Scotland issued in 23 accordance with the passage we were talking about 24 earlier, where you had been asked, I think in succession 25 to the previous body, to monitor the medical Page 67
1 Q. But where Healthcare Improvement Scotland may have 2 a role in this, or indeed its predecessor bodies, would 3 be the way in which that system is overseen and run by 4 entities like a health board, for example? 5 A. Yes. 6 Q. And that's done -- we've heard evidence already -- 7 through someone called the responsible officer? 8 A. Yes. 9 Q. And that, I think, is often, if not always, the medical 10 director of a health board when we're talking about 11 a health board? 12 A. Yes. 13 Q. So, you say at paragraph 10.8: 14 "At the request of the Scottish Government, HIS set 15 up a programme of annual review of medical appraisal and 16 revalidation in Scotland building on preparatory work 17 undertaken by NHS QIS and commenced the first review in 18 2012. The annual review programme continued for 19 five years and after publication of 2016-2017 report the 20 responsibility for undertaking this process was passed 21 to ... NHS Education for Scotland (NES)." 22 Which we've discussed already. You then go on to 23 say: 24 "HIS has a close working relationship with NES. 25 This entails the sharing of knowledge and intelligence Page 66	1 revalidation and appraisal process that was going on for 2 doctors in Scotland? 3 A. That's correct. 4 Q. This is an extensive piece of work I think that covers 5 the whole country, is that right? 6 A. Yes, it does. 7 Q. And so in this document what we see is the specific 8 sections relating to the extent to which the medical 9 revalidation and appraisal processes within all of the 10 health boards, and I think perhaps wider than that, is 11 covered? 12 A. Yes. 13 Q. And this carried on after this report for a number 14 of years, I think to 2016-17, I think you said? 15 A. Yes, to 2016-17 and then it transferred to NHS Education 16 for Scotland. 17 Q. Thank you. And do you know why it was -- although this 18 was under the previous regime, I think -- that the 19 Scottish Government felt it important that this aspect 20 of the provision of medical healthcare services in 21 Scotland be monitored in this way? 22 A. Although I wasn't involved in the preparatory work as 23 I hadn't joined Healthcare Improvement Scotland at that 24 time, but I suppose the key driver around this was in 25 relation to ensuring that doctors were -- there was Page 68

1 an assurance system in relation to fitness to practice, 2 but ultimately that doctors practising in the NHS were 3 up to date with their skills and there was a robust 4 process of appraisal that could ultimately lead to 5 revalidation of their licences with the General Medical 6 Council. 7 Q. Thank you. In essence this was a very important part, 8 was it not, of what the GMC required in terms of 9 clinical governance of medical standards? 10 A. Yes, absolutely and the importance of individual 11 responsible officers within boards in ensuring 12 compliance with that. 13 Q. Yes, and as we discussed earlier, that perhaps was the 14 component that your organisation was interested in to 15 the extent that you're not focusing on the individual 16 doctors, you're focusing on the systems which facilitate 17 the individual doctors to raise their standards, if you 18 like? 19 A. Yes, absolutely and this system being one part of that. 20 Q. Understood. Could we look at page 4, please, where some 21 of the background is set out. It states there, under 22 "introduction": 23 "In Scotland, providing safe, effective and 24 person-centred care is central to the Scottish 25 Government's Quality Strategy. Revalidation supports Page 69	1 practice and the way they interact with their patients 2 and colleagues. From December 2012, all doctors, 3 including medical trainees, need to prove that they are 4 up to date (complying with relevant professional 5 standards) and fit to practise." 6 And reading a paragraph down, it says: 7 "In Scotland, the initial phase of medical 8 revalidation will take place between December 2012 and 9 the end of March 2016 and doctors have been selected for 10 revalidation by a strict randomisation process based on 11 their General Medical Council ... number. On this basis 12 the GMC expects to revalidate: 13 "Responsible Officers (ROs) and [their] medical 14 leaders by September 2013. 15 "20% of eligible doctors between April 2013 and the 16 end of March 2014. 17 "60% by of eligible doctors by the end 18 of March 2015, and ... 19 "100% by the end of March 2016. As at the 20 1 September 2013, the GMC reported that in Scotland, 21 1,299 doctors had been revalidated. About 190 had had 22 their revalidation date rescheduled, known as 23 'deferral'. There were no reported cases of doctors 24 failing to engage in the revalidation process. Any 25 doctors, who are unable to complete this initial phase Page 71
1 these aims and also complements the work of the Scottish 2 Patient Safety Programme. In Scotland, there are more 3 than 15,000 practising doctors, 95% of whom are employed 4 by the NHS and secondary care (hospitals) or primary 5 care (general practice)." 6 If you're able, Mr Pearson, the documents referred 7 to the Scottish Government's quality strategy and the 8 Scottish Patient Safety Programme. If you could provide 9 any more information on those that would be helpful but 10 are these basically general government strategies about 11 trying to raise the standards of healthcare? 12 A. Yes, absolutely, and the quality strategy published in 13 2010 was an important part of providing the foundations 14 around quality, around a person-centred, safe and 15 effective health and care system. And the Scottish 16 Patient Safety Programme established in 2008, 17 an important part of ensuring that clinical care 18 processes at the front line were as safe as possible. 19 Q. Thank you. The document goes on to say, in the 20 specifics of this piece of work: 21 "The aim of revalidation is to give patients 22 confidence that their doctors are performing well, and 23 are aware of the latest developments in the area of 24 medicine in which they practise. It will also help 25 doctors to reflect on how they can improve their Page 70	1 in the timescales outlined above, must make arrangements 2 to renew their licence by the end of March 2018, if they 3 wish to continue to practise in the UK. 4 "This compendium of reports should be read in 5 conjunction with 'From readiness to revalidation: 6 a report on medical revalidation progress in 2012-13'." 7 So that sets out some of the context, perhaps, in 8 which this scheme of monitoring that Healthcare 9 Improvement Scotland was carrying out, there was a kind 10 of phased introduction over a number of years and 11 I think that coincides broadly with the period 12 Healthcare Improvement Scotland was monitoring this -- 13 the progress, presumably to make sure that everything 14 was going on -- was on target if you like? 15 A. Yes. 16 Q. It says on the next page, page 5, if you just jump over, 17 in relation to findings, it says: 18 "The analysis of the self-assessment focused on the 19 following four key areas that support the revalidation 20 process." 21 I wondered if you could help us with the concept of 22 "self-assessment" there, what's that referring to? 23 A. Yes, so individual boards would be coming back to 24 Healthcare Improvement Scotland with a statement where 25 they were with issues around the number of appraisals Page 72

1 trained, whether they had infrastructure around the 2 responsible officer. So a number of things would be 3 coming back from individual boards. It wouldn't have 4 been at that point in time, as I recall, an inspection 5 as such. It would have been material coming back into 6 Healthcare Improvement Scotland about where boards 7 thought they were in relation to that process. 8 Q. I see, so the self-assessment, if you like, is 9 an assessment by the board. The board is providing you 10 with the information you need, rather than you going in 11 to check for yourself, as it were, perhaps a feature of 12 this being such a huge exercise that you couldn't go 13 into every single board; is that fair? 14 A. Yes. 15 Q. And it's split into four key areas there, where you talk 16 about the organisational details which include 17 responsibilities associated with their designated body 18 status, a revalidation action plan, a trained appraiser 19 plan and an audit of missed or incomplete appraisals. 20 All of those are part of the system that the health 21 boards are offering to try to make sure this system is 22 on target, isn't that right? 23 A. Correct. 24 Q. And also there are, within that, responsible officer 25 arrangements which are listed there, there are details Page 73	1 which HIS has sought from the boards, is that right? 2 A. Correct. 3 Q. Just on that one particular aspect, one of the things 4 that you were looking at there -- your organisation was 5 looking at was arrangements which were in place for 6 obtaining information on all new doctors from their 7 previous employing or contracting organisation. What do 8 you -- in broad terms, would it be expected that 9 an organisation would do when it employed a doctor that 10 had previously been employed somewhere else to check, 11 effectively, the credentials of that doctor to make sure 12 that they are fit to practice within the health board? 13 A. I don't know the detail on this exactly, but certainly 14 an expectation within that that organisations have a -- 15 new doctors coming into a new organisation would have 16 an understanding of the whole practice, not just within 17 the organisation they had joined. 18 Q. I see. And that it would be expected, would it be, that 19 there would be a reasonable amount of consideration and 20 assurance devoted to looking at the material that was 21 provided rather than just taking it by face value or 22 something like that? 23 A. That would be a reasonable assumption, yes. 24 Q. Thank you. And it's important that that is done to try 25 to make sure when new doctors come into a particular Page 75
1 about the appraisal system and that includes, in 2 particular: 3 "Management and a number of appraisals undertaken 4 both primary and secondary care throughout each NHS 5 board ... for appraisal years 2010-2011, 2011-2012, 6 2012-2012, and ... 7 "Support provided to appraisers including feedback 8 on performance." 9 Is that right? 10 A. Yes. 11 Q. And then under the final heading, which is "Governance 12 and business continuity", you've looked for clinical -- 13 your organisation has looked for: 14 "Clinical governance that supports revalidation and 15 informs the appraisal process. 16 "Arrangements in place for obtaining information on 17 all new doctors from their previous employing [or] 18 contracting organisation. 19 "A process are remediation, rehabilitation and 20 targeted support, and ... 21 "Systems and processes to support doctors continued 22 professional development." 23 So this is all the information, all of the 24 components, if you like, of an effective system of 25 medical revalidation and appraisal, information about Page 74	1 area, that their standards are appropriate to the tasks 2 they will be undertaking? 3 A. Yes. 4 Q. Could I ask you, please, to look at page 39 of the 5 document. As I said a moment ago, the document is split 6 into many, many different health boards and 7 organisations but here, we see the assessment of what's 8 happening within NHS Tayside. We see various 9 statistical information at the top and there are, over 10 the next three pages, information about the assessment 11 that's been undertaken by Healthcare Improvement 12 Scotland, is that right, as to where they've got to by 13 this point? 14 A. Yes. So there would have been a panel, I think, 15 decision made in relation to the evidence that had been 16 provided and a summary of that provided within the 17 context of this report. 18 Q. Thank you. In section 3, the appraisal system is looked 19 at and it's described as being "not on target". What 20 does that mean? 21 A. Well, not on target in relation to the original 22 expectations, as I understood it at that point, and 23 a number of areas in which a panel could not make 24 an assessment as to progress that was being made. 25 Q. So, for example, if you just jump back to page 37, you Page 76

1 see there -- down a bit, thank you. You see there, this 2 is the NHS Shetland section, their appraisal system is 3 on target in this regard. Again, going back to page 35. 4 Sorry, let's go to 32. So as not to pick Orkney and 5 Shetland, I will go to NHS Lothian. On page 32, you see 6 the appraisals and this is NHS Lothian, again, on target 7 for this section, is that right? 8 A. Yes. 9 Q. So if we can go back to page 39, please. "Not on 10 target" is what is said at the top and goes and to give 11 more information about the assessment of the 12 documentation that's been provided, where it says: 13 "The panel requested further information on 14 appraisal rates, as while there has been progress 15 compared with previous results, only 77% of doctors had 16 an annual appraisal in 2012-2013. Most of these are in 17 primary care. Of the doctors due for revalidation in 18 2013-2014, 83% had an appraisal in 2012-2013." 19 So do you take that to mean that most of the 77% of 20 the total were in primary care, is that right? 21 A. "The panel requested further information on appraisal 22 rates, as while there has been progress ..." 23 Yes, most of those -- as it says in the second 24 sentence, most of these are in primary care. 25 Q. I just wondered whether that meant if one were to look Page 77	1 I think is NHS Education for Scotland] to refer any 2 interested doctors for appraisal training and plans to 3 make sure there are sufficient NES-trained appraisers 4 for future years. The appraisal lead meets with 5 specialty doctors to take up the NES training. 6 "There is currently no system in place for 7 appraisees to feedback on the appraiser's performance. 8 The NHS board proposes to carry this out in 2013-2014. 9 This function is available on SOAR, which is being used 10 to manage multi-source feedback." 11 SOAR is a computer system? 12 A. Yes, it's a computer database system and I can't recall 13 exactly what that acronym stands for. 14 Q. Okay, thank you. It says: 15 "Patient feedback is collated by clinics at a local 16 level until 25 CARE questionnaires are collected. Once 17 patient feedback is complete, the forms are scanned in 18 and an Excel report is generated. This is then sent to 19 individual doctors for inclusion in their appraisal 20 portfolio. This has worked well for the NHS board so 21 far. Any recommendations and improvements are taken to 22 the revalidation steering group for further discussion 23 and then implemented by the appraisal lead and the 24 relevant team. 25 "The appraisal lead checks all Form 4s for quality Page 79
1 just at secondary care the figure would be lower than 2 77% because most of the 77% of the total were in primary 3 care, is that right? 4 A. I wouldn't want to necessarily land on an answer on 5 that, if I may. I think it needs a bit of care as to 6 just what that wording meant. 7 Q. Understood. Thank you. It goes on to say: 8 "It was difficult for the panel to make any 9 assessment on how these remaining doctors were going to 10 be appraised and revalidated. NHS Tayside did not 11 submit a trained appraisers plan and did not report 12 on any audit of missed and incomplete appraisals." 13 Is that what it says? 14 A. Yes. 15 Q. It says: 16 "As there was no medical appraisal policy in place, 17 NHS Tayside reported how it managed the allocation of 18 appraisers and appraisees. Previously this was done by 19 specialty, but in the future each appraisee will change 20 appraiser after 3 years. New doctors are allocated to 21 an appraiser on the basis of the number of appraisees 22 that appraiser already has allocated. To date, each 23 appraiser carries out an average of 6 appraisals each 24 year. 25 "NHS Tayside is working close with NES [which Page 78	1 of input from both appraiser and appraisee. The medical 2 director reviews a random selection of Form 4s and will 3 also see any brought to his attention by the team. The 4 medical director and the appraisal lead mediate any 5 disputes." 6 What I have read out, is that what it says, those 7 are the findings? 8 A. Yes. 9 Q. And just on a couple of points of detail, we've heard 10 some evidence already from the Medical Director of 11 NHS Lothian about there being a part of this system 12 that -- you may know about the detail, you may not -- 13 where there is a requirement to get some patient 14 feedback, a certain number, I think, over a year. Is 15 that what the patient feedback questionnaires are 16 referring to, as far as you understand? 17 A. As far as I understand it, it's a multi-source feedback, 18 if that's the best way to describe it. 19 Q. Can you help us with "form 4s"? That may be too much 20 detail. 21 A. That's probably too much detail in relation to that one, 22 yes. 23 Q. Okay, that's fine. And over on the next page, page 41, 24 the action points from the 2012 review are pointed out. 25 It says: Page 80

20 (Pages 77 to 80)

1 "Formalise arrangements for deputy [Responsible 2 Officers] and arrange [Responsible Officer] training for 3 deputy [Responsible Officer] to support and promote 4 business continuity." 5 It says that was fully actioned, is that right? 6 A. Yes. 7 Q. And it says that also fully actioned was the requirement 8 to: 9 "Implement a clinical governance structure to 10 support medical appraisal and revalidation." 11 Is that right? 12 A. Yes. 13 Q. However, "ongoing" were described as the task to sign 14 off and implement the appraisal guidance policy, is that 15 right? 16 A. Yes. 17 Q. And also "ongoing" is the description given to the 18 requirement to: 19 "Continue to monitor appraisals and meet the 20 criteria for the number of doctors going forward for 21 revalidation throughout year 1. Plan, co-ordinate and 22 continue to develop processes for the increasing number 23 of doctors going forward in years 2 and 3." 24 So that -- do I take it to mean that those things 25 have not yet been completed but there are processes Page 81	1 done by HIS robustly to pursue those recommendations? 2 A. So in relation to recommendations and requirements and 3 maybe just separate the difference between 4 a recommendation and a requirement. A recommendation is 5 where there is good practice and we asked the board that 6 they should seek it adopt it. The standards are 7 different. We express a statement -- the word is 8 "must" -- and what we do in relation to after the actual 9 inspection, is 18 weeks after the inspection we follow 10 up with the board and then we follow up with the board 11 one year after that as well. 12 If we return, in serious circumstances, and discover 13 there has not been sufficient seriousness, action taken 14 by the board in response to, for instance, 15 a requirement, then we are into potential escalation of 16 the board, if they cannot give us a satisfactory answer 17 as to why they have not addressed the requirements from 18 an inspection. 19 That then takes us into an escalation either to the 20 chief executive of the board, or alternatively into 21 escalation to Scottish Government. And then Scottish 22 Government will consider this escalation in the context 23 of other intelligence and concerns they may have in the 24 performance management of that board. 25 THE CHAIR: In what circumstances would you go direct to the Page 83
1 towards their completion, would that be fair? 2 A. Yes, that's correct. 3 Q. Thank you very much. And it suggests action points from 4 the 2013 review would be to: 5 "Continue to monitor and increase annual appraisal 6 rates and aim for at least 95% of completed appraisals. 7 "[And to] develop and implement a trained appraisers 8 action plan and medical revalidation plan." 9 So those were the suggestions, I think, being made 10 by HIS as to what needed to be done at that time, is 11 that right? 12 A. Yes. 13 Q. Thanks very much. Just give me one second. Yes, 14 I wanted to ask you a couple of questions arising out of 15 some of the matters we discussed earlier to do with the 16 ability of Healthcare Improvement Scotland, I think you 17 said, robustly to pursue the outcome of investigations 18 or other intelligence-gathering mechanisms where it 19 comes to a point where it's making recommendations that 20 something needs to be done to improve the quality of 21 healthcare being provided. 22 I think, as I understand it -- well, can you tell me 23 what it is that once the recommendations have been put 24 in place, and once the recommendations had been 25 intimated to the NHS healthcare provider, what can be Page 82	1 government rather than via the chief executive? 2 A. Sorry, could you repeat that? 3 THE CHAIR: In what circumstances would you bypass the chief 4 executive, if I have understood you correctly? 5 A. If the chief executive has had sufficient warning of our 6 concerns and has not responded sufficiently, we will 7 escalate to Scottish Government and make it clear the 8 rationale for doing so. 9 THE CHAIR: Thank you. 10 MR DAWSON: And what rules exist as to what the Scottish 11 Government needs to do in the event of such 12 an escalation to it? 13 A. So in the event it is escalated to Scottish Government 14 they have mechanisms called the "National Performance 15 Oversight Group" that has oversight of individual boards 16 in concerns or in escalation, wherever they sit between 17 1 and 5. And that body, as I understand it, will then 18 consider as to what action they may wish to take and 19 what recommendations we wish to put to the cabinet 20 secretary for intervention, based on our concerns. 21 Q. So that ultimately becomes a political decision, as you 22 say, in the context of other factors that the cabinet 23 secretary may or may not know about and whether that's 24 something they feels need to be pushed forward or not? 25 A. Correct. Page 84

1 Q. By that point, Healthcare Improvement Scotland's 2 function is over and it's been passed into someone 3 else's hands, is that right? 4 A. Yeah, that's correct. 5 Q. Presumably, the Healthcare Improvement Scotland who will 6 become involved again if, for example, more 7 investigation was required or a clarification of its 8 recommendations or requirements, for example? 9 A. Yeah, so what I would say is we don't, at that moment, 10 absolve ourselves of patient safety. We will follow up on 11 an inspection and do that in the context of the 12 requirements we may have put on that board. 13 Q. One of the things that you say in your statement is that 14 it's part of the remit of Healthcare Improvement 15 Scotland on behalf of the Scottish Ministers to support, 16 ensure and monitor the quality of healthcare provided or 17 secured by the health service. Insofar as your ability 18 to ensure is concerned, should that be read in the 19 context of that ultimately being the responsibility of 20 the Scottish Ministers because there's only so far that 21 your body can take that obligation? 22 A. That is -- that is correct. 23 Q. Yes, thank you. In the context of the processes that 24 you just -- 25 A. In the context of the processes I have just outlined. Page 85	1 context in which healthcare is delivered isn't just 2 about the individual system but the context and the 3 pressures across the country in relation to the delivery 4 of healthcare. So we published the report last -- 5 I think it was last September in relation to an overview 6 of inspections over the past four years and gave 7 a commentary about how the whole system and pressures 8 within that. And that, I think, gives an objective and 9 a fair account of the wider system in which it's 10 operating. 11 Q. Because I just wanted to understand -- I think you gave 12 some evidence earlier about the need to have a balance 13 between the various different functions and we looked, 14 a moment ago, at a document which showed, I think, 15 a very detailed across-Scotland analysis, albeit on 16 a documentation level rather than an inspection level, 17 of the progress towards the full implementation of the 18 medical revalidation and appraisal scheme. Would it be 19 fair to say that that sort of level of detail, which 20 does actually provide information about how things are 21 going on down the road from you, if you like, is quite 22 rare given the need for that balance to be maintained? 23 A. Sorry, what do you mean "rare", in the sense -- 24 Q. Rare in the extent to which it provides specific 25 information about, say, specific areas across the Page 87
1 Q. Thank you. Do you have an obligation as part of your 2 work to promote, amongst the public, information about 3 the quality of healthcare services available in 4 Scotland? 5 A. Yes, we do and we do that partly through our inspection 6 of boards but the other evolution that we have had as 7 an organisation, is we've moved from just talking about 8 an individual system, as you might look at in the 9 governance of an NHS board, to talking about the whole 10 system. And what I mean by that of NHS Scotland and the 11 quality of care delivered, that may include corridor 12 care, it may include delayed discharges, it may include 13 aspects of infection prevention and control. So it's 14 pushed us into -- and quite rightly -- into more of 15 an overview of the system as opposed to the individual 16 constituent parts of that system. 17 Q. But as far as -- I think you've told me that there is 18 an obligation to promote and inform the public about the 19 quality of healthcare available, is that right? 20 A. Yes. 21 Q. But are you saying there that that's a sort of 22 an overall impression rather than specifically related 23 to: how good is the healthcare provided down the road 24 from me? 25 A. Yeah, it's increasingly so, because we recognise the Page 86	1 country rather than it being the kind of more 2 generalised message that you've explained? 3 A. So the position right across the country, whether it is 4 in relation to maternity care or the care of older 5 adults or individual specific services that we have 6 reviewed, is down into that granular level about giving 7 a context and about what the quality of care is for 8 individuals experiencing in individual boards. 9 Q. Thank you. Could I just please have up paragraph 3.13 10 of the statement, which is HIS-00047, at page 6. We've 11 already touched on this in a general sense, Mr Pearson, 12 but it's paragraph 3.13, please, just zoom in at the 13 top. This is in relation to the extent to which 14 Healthcare Improvement Scotland or indeed its 15 predecessor bodies could have been involved in any 16 aspect of the Eljamel saga, as I put it broadly. You 17 say there -- again, this is in the context of providing 18 some historical information: 19 "As explained above, HIS has no responsibility for 20 the provision of healthcare services including 21 neurosurgical care services at NHS Tayside. As far as 22 I am aware, HIS has had no involvement with 23 neurosurgical care services at NHS Tayside due to the 24 fact that we have not received any intelligence or 25 evidence in relation though service or activities of Page 88

1 Mr Eljamel. We were also not asked to review this 2 service by the Scottish Ministers. Scottish government 3 officials did approach us in 2023 ..." 4 Which is further explained and we've gone into that 5 in some detail already. 6 So the position, as far as your researchers are 7 concerned, is that Healthcare Improvement Scotland did 8 not receive any intimation that there was any problem 9 with a neurosurgical service at Ninewells or with 10 Mr Eljamel at any stage? 11 A. No, we didn't and I think this comes back probably to 12 a point about professional practice, versus the whole 13 system. 14 Q. Yes, but it would be, would it not, premature to decide 15 this is not a matter for Healthcare Improvement Scotland 16 because it's not a systemic issue, it would rather be 17 a matter for Healthcare Improvement Scotland where there 18 were issues with the care being provided to a number of 19 patients, for you to determine whether it was a systemic 20 issue or not? 21 A. Yes, I think in relation to the history of the 22 neurosurgical service and Mr Eljamel, there was not 23 signals at that point over the journey in relation to 24 wider systemic points which would have required 25 Healthcare Improvement Scotland or indeed at rather -- Page 89	1 For example, we heard evidence last week from the 2 Executive Medical Director of NHS Lothian who was 3 instructed to undertake a review in relation to systemic 4 aspects of the Eljamel saga in 2018; are you aware of 5 that now? 6 A. Yes. 7 Q. And again, that's something that Healthcare Improvement 8 Scotland could have been asked to become involved in, 9 isn't that right? 10 A. That's correct. 11 Q. Because that was a systemic review which is very much 12 within Healthcare Improvement Scotland's expertise and 13 remit? 14 A. Yes. 15 Q. As far as NHS Tayside potentially being the instructing 16 agent to Healthcare Improvement Scotland for a review of 17 that general nature, to what extent is there 18 an obligation on a health board to bring such matters to 19 Healthcare Improvement Scotland's attention rather than 20 it being a matter of their choice? 21 A. If we come back to the overall context for boards in 22 relation to their duty of clinical governance, I think 23 that is a very important point that when boards approach 24 Healthcare Improvement Scotland to do something like 25 that, they should recognise the seriousness in relation Page 91
1 I can't talk for my predecessor bodies but in terms of 2 research we've done, we could not find it. 3 Q. Well, are you aware of the fact that NHS Tayside 4 commissioned an Invited Review Mechanism review relating 5 to the Eljamel saga in 2013? 6 A. I am aware of that from this Inquiry but not at that 7 time. 8 Q. Yes, understood. Are you aware of the fact that 9 although that was an individual review, it also called 10 upon the Royal College of Surgeons of England to comment 11 upon aspects of the systems which they might find 12 matters that they could helpfully comment on? 13 A. Yes, I am, yes. 14 Q. And insofar as the systems aspect is concerned, that is 15 something that Healthcare Improvement Scotland could 16 have been asked to comment on by NHS Tayside? 17 A. Correct. 18 Q. Could have been asked to comment on, if they were aware 19 of it, by the Scottish Government? 20 A. They could have. 21 Q. But that didn't happen? 22 A. That didn't happen. 23 Q. And indeed, we are aware through this Inquiry -- and 24 I'm sure you are aware at least now -- that there were 25 a number of subsequent investigations that took place. Page 90	1 to that duty but also the role of Healthcare Improvement 2 Scotland. Because if we had been asked to do that, we 3 would have carried out a review and we would have 4 published the findings. 5 Q. There are a couple of other aspects of the work of 6 Healthcare Improvement Scotland that you helpfully -- or 7 perhaps more generally in the whole system -- that you 8 mention, one is the quality assurance framework and you 9 give quite a lot of detail and provided some documents 10 to us about that. Could you give us a broad description 11 what have that entails, what's that about? 12 A. So the quality assurance framework was bringing together 13 a number of dimensions that will work against, 14 I think -- not a memory test -- but in terms of seven 15 domains, including governance involving of staff and 16 patients. And underpinning that, there are a number of 17 important documents with regards to standards, with 18 regards to the health and care standards in Scotland but 19 also other aspects of NHS standards in relation to 20 infection prevention and control. So it was bringing, 21 in an aggregate way, those key dimensions of our work. 22 Q. You have mentioned infection control a few times during 23 your testimony. Is that something which, on 24 balance, takes up a lot of time and attention and focus 25 within your organisation? Page 92

1 A. In the very outset of the Healthcare Environment 2 Inspectorate and on the back of the Vale of Leven 3 tragedy, that was a heavy part of the role of the 4 healthcare environment, which was subsequently absorbed 5 into Healthcare Improvement Scotland. Infection 6 prevention and control was at the heart of it. Patients 7 died in the Vale of Leven and this was about ensuring we 8 had robust standards about the cleanliness and the 9 safety of care within our hospitals. 10 Since then we've moved on to matters that are, 11 I suppose, tougher in relation to leadership, in 12 relation to culture, in relation to behaviours and we've 13 moved away from, I suppose, a system about which might 14 have been a little binary in respect of: is this 15 hospital clean or is it not clean? To matters of 16 judgment about leadership and governance and culture in 17 the system. 18 Q. So that's a helpful understanding of the evolution. Is 19 the current system -- why has there been that evolution? 20 Why is it important that you focus on those aspects that 21 you now focus on? 22 A. These are important parts as the evolution of Healthcare 23 Improvement Scotland because leadership and culture, the 24 tone from the top -- I used that phrase earlier -- sets 25 the behaviours, the context, the openness or otherwise Page 93	1 neurosurgical service, given these other priorities, 2 would you have had the capacity to do that? 3 A. We would have done it. The important point is that at 4 different points -- and I think it's in the legislation 5 somewhere -- that ultimately we can be directed by 6 ministers in relation to their priorities. So we would 7 have to re-prioritise within that. And indeed, 8 I suppose it's back to where we were with Ayrshire and 9 Arran, that I'd arrived 1 March and that was my first 10 job. 11 Q. Yes, in 2012? 12 A. In 2012. 13 Q. Okay. Another aspect of the evidence that you've given 14 which we haven't come across before so I asked you just 15 to give an outline of it, is you've been asked some 16 questions in relation to whistleblowing, which is 17 an important part of our Terms of Reference and you 18 mention in your report at paragraph 11.6 that: 19 "In April 2013, Scottish Government launched the 20 National Confidential Alert Line ... This is a free, 21 confidential telephone line to allow NHS employees to 22 raise any concerns about practices in NHS Scotland. The 23 alert line would pass any concerns raised by employees 24 on to the employer or the relevant regulatory 25 organisation for [the] investigation. [And] HIS was Page 95
1 within a health system. 2 Q. And just in terms of the timescales we're talking, 3 obviously Healthcare Improvement Scotland started in 4 2011, you've mentioned there being a period when the 5 focus was largely on these important infection control 6 aspects of healthcare. And then there being 7 an evolution into looking at the top and trying to work 8 out better systems of doing things. Could you give us 9 an indication in terms of timescale as to when that, the 10 move away from focusing largely on the infection aspect 11 of things happened? 12 A. It's been an evolution. I wouldn't want to necessarily 13 put a precise date on it, but if you think about when we 14 started to do inspections of the care of older adults in 15 Scotland which was around 2012, that evolved into other 16 aspects beyond infection prevention and control, about 17 hydration, about other aspects of the direct care of 18 patients. As we've gradually moved into the last two or 19 three years, a much stronger focus, I suppose, on 20 leadership and culture and the extent to which that 21 quality assurance framework, in the past couple 22 of years, has been important. 23 Q. Okay, and in the period from 2011 to 2013, if you had 24 been asked by Scottish Government, NHS Tayside, to 25 undertake a review of the systems around Mr Eljamel, the Page 94	1 identified by Scottish Government as one of the relevant 2 organisations." 3 First of all, how important is that innovation 4 in April 2013 with regard to the promotion of what one 5 might broadly call "whistleblowing" although there's 6 a support element for doctors I think in it as well? 7 A. Yes. So it was an important step in relation to 8 providing a level of access for staff who wished to come 9 forward anonymously and had concerns about the safety of 10 care within their local organisation. It was run by, as 11 I recall, an organisation called Protect and it was 12 subsequently changed in the context of the INWO, 13 Independent National Whistleblowing Officer 14 responsibilities. 15 Q. And in terms of HIS being, I think you call it, 16 a relevant organisation, what does that mean? Or is it 17 I think "prescribed organisation" is used somewhere? 18 A. So at that point we weren't a prescribed person in 19 relation to the Public Interest Disclosure Act, that 20 came in, I think, in 2014 and but at that point, I'm not 21 sure whether it was a statutory or non-statutory basis 22 for the word "relevant". But we were an organisation 23 which the National Confidential Alert Line, NCAL, could 24 refer concerns to us. 25 Q. I see. So you then become, if I understand this Page 96

1 correctly, part of this kind of confidential bubble in 2 which these important concerns which are raised through 3 this mechanism can be discussed and escalated to 4 regulatory bodies or whatever you consider appropriate, 5 is that right? 6 A. That's correct. 7 Q. Thank you. Could we have a look, please, at HIS-00018. 8 Could you tell us what this document is, please? 9 A. Yes. So we established the Sharing Intelligence for 10 Health & Care Group in April 2015 and this was us 11 testing, with six different bodies, the ways in which we 12 could share intelligence. And I'll come on to the 13 document itself, but very much driven by the 14 Francis Inquiry and concerns about bodies that had 15 failed to share information and intelligence between 16 them. So this was the first attempt in relation to 17 bringing and convening, I think in those days it was six 18 bodies around the table and those individuals -- 19 individual bodies putting on the table the intelligence, 20 as they understood it, in relation to NHS Tayside. 21 Q. And so the context of this is -- what gave rise to the 22 idea that this investigation, if you like, would take 23 place within NHS Tayside as opposed to somewhere else? 24 A. Well, what would have happened in those days was it 25 happened in a rotation of individual boards. You would Page 97	1 during this meeting." 2 I think actually at the bottom, the bodies that were 3 part of the group are listed, I think the six that you 4 mention. And so, is this -- this is a process in which 5 the body is sitting, looking at the information 6 available about NHS Tayside and trying to work out 7 whether that gives any cause for concern, is that 8 broadly what's going on here? 9 A. Yeah, or matters of concern or matters of intelligence 10 that would, if in isolation, considered not perhaps 11 particularly significant but connected to another piece 12 of intelligence for another body, might gather a greater 13 prominence and significance than otherwise would be the 14 case. 15 Q. And was this being done, at this stage, by NHS Tayside, 16 did you say as a matter of sort of rotation, or was 17 there a particular reason to be looking at NHS Tayside 18 as opposed to any other health provider? 19 A. It was absolutely, as I recall, by rotation. We'll go 20 through -- and it might even have been in alphabetical 21 order, I don't know, but in relation to --. 22 Q. So the different bodies then, you say: right, we have 23 a meeting, next week or whatever, we're going to discuss 24 NHS Tayside, that's -- it's their turn. Can people 25 bring to the meeting any concerns or intelligence that Page 99
1 go from borders all the way through individual boards 2 and they would meet on a regular basis to cover three or 3 four boards over the course of a whole day. And in 4 that -- in these meetings, there would be an opportunity 5 for NHS Education for Scotland to share issues about the 6 quality of the resident doctors -- in those times, 7 junior doctors' training environment, for instance, 8 Audit Scotland would work information work it was doing, 9 etc. 10 Q. So, as a result of a meeting of that nature and the 11 intelligence, I think you've said, being collated and 12 considered, was it then thought appropriate to conduct 13 some sort of investigation into NHS Tayside? 14 A. Not at that point. What that body was doing was 15 avoiding the impression that it was becoming a sort of 16 quasi-statutory body to do its own investigations above 17 and beyond the existing entities. At that point it was 18 an opportunity to share as much as was known and how 19 much people felt safe to share about aspects of the work 20 they were doing within their individual organisations. 21 Q. So this document says, at the top, that: 22 "On 17 August 2015, the Sharing Intelligence for 23 Health & Care Group considered a wide range of 24 data/information about NHS Tayside. [And the] note 25 summarises the key conclusions reached by the group Page 98	1 they have and we can -- a word we've heard before is 2 "triangulate" the different sources of data about what's 3 going on there, would that be fair? 4 A. In essence that was it, and bringing in as much as it 5 could and felt comfortable about sharing on to that 6 table and that was the basis of it. 7 Q. As far as the specifics, without going into the minute 8 details of this, there are a number of topics that 9 appear to be covered here as being sorts of areas that 10 perhaps different bodies have brought intelligence to 11 the table about. You can see in paragraph 3 that 12 infection control standards were discussed. In the next 13 paragraph mental health and learning disability services 14 were discussed. The next paragraph NHS Tayside's budget 15 and the possibility that there had been an overreliance 16 on non-recurring savings were discussed. And in the 17 next paragraph it's pointed out that there's a high 18 proportion of excellent social care services within the 19 NHS Tayside remit. 20 Were these the sorts of things that tended to be 21 brought to the table by the bodies at around this time? 22 Infection control, for example, you've said was a major 23 focus in the early years and that's included there. But 24 would there be a sort of -- given the nature of the 25 bodies involved, would there therefore be a kind of Page 100

1 standard type of information, type of intelligence that 2 would be brought to the table which perhaps might then 3 dictate the sorts of subject matter that would be 4 discussed? 5 A. Yeah, at that point in time this was in the most, 6 I suppose, earliest and basic attempt at bringing this 7 together to: what do we have within our individual 8 repositories, if that's right way to describe it? And 9 as it evolved over time we formulated a much stronger 10 understanding of the warning signs -- and you'll see 11 that in the framework about signals in the system. 12 Q. Yes. 13 A. -- but at that point in time it was trying to create 14 a culture which did not exist prior to that of people 15 coming to the table and saying: this is what we've got. 16 Q. Understood. It says in the penultimate paragraph, a bit 17 further down: 18 "The group noted that when the Board of NHS Tayside 19 recently considered the Board performance report, the 20 Chief Executive advised of the potential for there to be 21 a significant deterioration in performance. NHS Tayside 22 has raised this with the Scottish Government." 23 Is that a particular aspect that you can recall 24 there being -- can you recall what that was about? 25 A. No, I cannot recall exactly what aspect of performance Page 101	1 a sensitivity towards detecting those sorts of signs 2 internally whether your organisation is involved or not? 3 A. Absolutely. Every board could take a warning signs 4 statement, and the indicators within it which is 5 evidence based from multiple concerns and tragedies over 6 the United Kingdom looking a governance, looking at 7 culture, looking at safety, and look at themselves 8 internally and say: where do we sit in this? 9 MR DAWSON: Thank you very much. 10 Those are my questions, sir. Thank you. 11 THE CHAIR: All right. Mr Pearson, we'll take another short 12 break. There may be some further questions but that is 13 the subject of potential discussion at this time. So if 14 you go with Ms Miller and we will begin again shortly, 15 thank you. 16 (12.35 pm) 17 (A short break) 18 (12.45 pm) 19 THE CHAIR: Right. 20 MR DAWSON: Nothing further, sir. Thank you very much 21 Mr Pearson. 22 THE CHAIR: Mr Pearson, as you'll have gathered, that 23 concludes this evidence session and shortly I'll be 24 saying you are free to go. But before I do, I would 25 like just to say this; that the Inquiry, and indeed I, Page 103
1 was deteriorating at that point. 2 Q. Would it be normal for a health board to sort of predict 3 a deterioration in performance in that way? 4 A. If it had concerns in relation to a number of 5 indicators, it may be the lay discharges, it may be in 6 relation to the financial position, it may be looking 7 ahead and thinking: we've got a concern here, do we need 8 to escalate it to Scottish Government. 9 Q. Thank you. Those are all the questions that I have for 10 Mr Pearson, sir. At this stage I would invite you, 11 Mr Pearson, is there anything else you would like to 12 add? 13 A. One thing I would like to emphasise is the fundamental 14 importance of signals and warning signs in the system 15 and avoiding a compartmentalisation of that. The 16 quality of care can't afford that so an importance then 17 becomes on patient safety, professionalism and I think 18 personal behaviours as well. 19 Q. Just on that, if I may, sir. You've mentioned the 20 increasing awareness of the group, the intelligence 21 group you talked about there of developing a sensitivity 22 towards the sorts of signs that might be required. Is 23 it important for organisations like health boards 24 themselves because as you've told us they have statutory 25 responsibilities towards healthcare to develop Page 102	1 fully appreciate how much work goes into the generation 2 of statements of the kind that you have spoken to today 3 and the associated documentation that has been 4 accumulated by the diligent searches of you and others. 5 So, with that in mind, can I extend to you both the 6 Inquiry's thanks and my personal thanks for your 7 attendance and for all of that work. You are indeed now 8 free to go. Thank you. 9 A. Thank you, sir. 10 THE CHAIR: Quarter to? 11 MR DAWSON: Thank you, sir. 12 THE CHAIR: One hour, ladies and gentlemen. Thank you. 13 (12.46 pm) 14 (The short adjournment) 15 (Proceedings delayed) 16 (1.58 pm) 17 THE CHAIR: Yes, good afternoon. 18 MR DAWSON: Sir, the next witness is Peter James. 19 THE CHAIR: Thank you. 20 MR PETER JAMES (sworn) 21 Questions by COUNSEL TO THE INQUIRY 22 THE CHAIR: Mr Dawson. 23 MR DAWSON: Thank you, sir. You are Peter James? 24 A. I am. 25 Q. Could you, during the course of your evidence, Mr James, Page 104

1 try to speak into the microphone as best you can just to 2 make sure everybody can hear loud and clear what you're 3 saying. 4 You provided a witness statement to the Inquiry on 5 behalf of Circle Health Group; is that correct? 6 A. That's correct. 7 Q. Could we have CHG-00245 up on the screen, please. Is 8 that your statement? 9 A. It is. 10 Q. Could we go to page 57, please. Does your signature 11 appear underneath the "CAT C" emblem? 12 A. It does. 13 Q. This witness statement is dated 13 May 2026; is that 14 correct? 15 A. That's correct. 16 Q. And are the contents of this statement true? 17 A. They are. 18 Q. Thank you. Mr James, you are the Chief Medical Officer, 19 I think, of Circle Health Group; is that correct? 20 A. That is correct. 21 Q. Can you tell me please what your role as the Chief 22 Medical Officer of Circle Health Group involves? 23 A. Yes, as Chief Medical Officer at Circle Health Group, 24 I have overall responsibility for quality of clinical 25 care delivered within the Circle Health Group family of Page 105	1 Health Group. That makes me their direct responsible 2 officer. 3 That role allows me or commits me to evaluating the 4 performance of that doctor to look at their -- yeah, 5 their general performance, and make recommendations to 6 the General Medical Council about suitability to 7 continue to practise. 8 Q. And for doctors who work within the Circle Health Group 9 as well as with an NHS practice, effectively that means 10 they have more than one responsible officer, is that 11 right? 12 A. No, all doctors only have one responsible officer and 13 that is the -- provided by their designated body. There 14 is an algorithm which is published by the General 15 Medical Council about where that connection sits for 16 a doctor. The vast majority of doctors, because they do 17 the majority of their work within the National Health 18 Service will use the National Health Service primary 19 hospital as their designated body and therefore the 20 responsible officer will sit within that organisation 21 rather than with us at Circle Health Group. 22 Q. I see, and so does the GMC algorithm effectively tell 23 you, based on what that individual doctor's professional 24 commitments are, which the designated body or 25 organisation should be for the responsible officer to be Page 107
1 hospitals, reporting to the board. I am also the 2 responsible officer for Circle Health Group along with 3 the Chief Medical Officer role. That gives me 4 responsibility for managing the medical profession 5 within Circle Health Group hospitals, liaising with 6 a number of external bodies including the General 7 Medical Council for matters of revalidation and 8 performance, liaising now with fellow responsible 9 officers within other private providers or the National 10 Health Service to discuss matters relating to 11 consultants. 12 Obviously a responsibility to the private medical 13 insurers and to the NHS, if we do NHS work in our 14 hospital, and of course responsibility to the patients 15 that we treat to ensure that care is the best possible 16 level it can be within our hospitals. 17 Q. Thank you. We've heard the expression "responsible 18 officer" from other witnesses in the context of the NHS. 19 Is the role which you play exactly the same as 20 a responsible officer would be within the NHS? 21 A. It is. Every designated body has to have a responsible 22 officer. Circle Health Group is a designated body. By 23 that I mean that we have consultants doing full-time 24 private practice that work within our hospitals. They 25 are connected -- or many of them are connected to Circle Page 106	1 selected, effectively? 2 A. That's correct. 3 Q. I see. So if you had -- presumably, are there doctors 4 who work exclusively within the private sector? 5 A. There are doctors who work exclusively within the 6 private sector. Those doctors may work for more than 7 one hospital provider. So it could be Circle Health 8 Group, where I work. Could be Spire Healthcare, any of 9 those providers. The algorithm that dictates which 10 provider acts as their designated body is based on where 11 they do the majority of their clinical work. 12 Q. Understood, thank you. You are a retired consultant 13 orthopaedic surgeon yourself; is that correct? 14 A. I am; that's correct. 15 Q. And during the course of your career you worked in both 16 NHS and in private facilities, is that right? 17 A. I did. 18 Q. Could I ask you, please, to look at paragraph 1.3 of the 19 statement at page 2. It will come up on the screen. 20 You mention there, amongst your qualifications, that you 21 are FRCS and FRCS (Orth). Could you explain what those 22 abbreviations stand for? 23 A. Yes. So FRCS stands for Fellow of the Royal College of 24 Surgeons. I passed my fellowship in 1989 through the 25 English college. At the time that I passed that exam, Page 108

27 (Pages 105 to 108)

1 the Intercollegiate Specialty Board or the joint Royal 2 Colleges introduced a further examination and 3 qualification required before you could exit as 4 a consultant. They were specialty examinations. 5 Clearly, because I wanted to be an orthopaedic surgeon 6 I did advanced training in orthopaedic surgery and then 7 in 1994, sat the FRCS (Orth) which is, again, 8 a fellowship of the Royal College of surgeons but 9 specifically in the subject of trauma and orthopaedics. 10 Q. I see. So is the fact that you have both of those 11 acronyms after your name a peculiarity of orthopaedic 12 surgery or does that -- does one expect to see that of 13 perhaps doctors of your generation that there would be 14 the two fellowships? 15 A. Doctors of my generation often would have both 16 qualifications. It is more a factor of the timing of 17 your journey through the training programme. At the 18 point I sat the FRCS in 1989, there was no further 19 examination. That was introduced in my time training to 20 do orthopaedics. So it was, if you like, a bit of 21 an extra hurdle for my generation that was put in. So 22 my generation you will often see this. 23 Q. Thank you. And as far as your responsibilities in your 24 role as Chief Medical Officer of Circle Health Group are 25 concerned, do I understand it correctly if I were to say Page 109	1 word. Those doctors then work in our facilities and 2 have access to our facilities but have to abide by our 3 policies and governance processes in order to continue 4 to work in those facilities. 5 Overall, the clinical governance framework that 6 exists, certainly now in the independent sector, is 7 virtually an exact mirror of the clinical governance 8 services that sit within the NHS institutions. 9 Q. I see and you say "now". Has that been a process of 10 evolution? 11 A. Clinical governance, as I'm sure you've heard from other 12 witnesses, has evolved significantly over the last 20 to 13 25 years, starting from, I think, quite local systems to 14 manage medical performance certainly in the independent 15 sector. And that has matured significantly into, 16 I think, what are now robust clinical governance 17 processes which we operate. 18 Q. And I think your statement tells us that there may 19 perhaps be aspects of clinical or professional 20 governance that exist within the NHS that don't apply 21 when one is working in a private hospital. For example, 22 there are systems and obligations relating to training 23 of junior colleagues which exist within NHS hospitals 24 which I think doesn't feature within the practising 25 privileges system that exists within a private hospital; Page 111
1 that your responsibilities don't relate to a particular 2 geographical area? 3 A. No, my responsibilities relate to the totality of Circle 4 Health Group and we -- for context, we run hospitals in 5 England, Scotland and Wales. 6 Q. And does it then follow that your responsibility is not 7 with regard to particular hospitals but all of the 8 hospitals within the group? 9 A. Apologies, yes, all of the hospitals within that group, 10 yes. 11 Q. Thank you. 12 THE CHAIR: Roughly -- never mind roughly. How many are 13 there? 14 A. 54. 15 THE CHAIR: 54, thank you. 16 MR DAWSON: Thank you. 17 When medical professionals are providing their 18 services within a private hospital, do they operate 19 within the same schemes of professional governance as 20 would exist within an NHS hospital, based on your 21 experience of both in your own career? 22 A. Within the private sector, the consultants who work in 23 our hospitals are not employees of the independent 24 provider. They work within our facilities via 25 a practising privileges model, which compels -- wrong Page 110	1 is that correct? 2 A. That is correct. We do not, in the independent sector, 3 train doctors. We work with doctors who are fully 4 trained to provide consultant-led services. 5 Q. We've heard some evidence from witnesses about the need 6 for there to be candour amongst professional colleagues, 7 certainly within the NHS context, relating to issues 8 which may have arisen within one's practice. For 9 example, we've heard some evidence about the concept of 10 mortality and morbidity meetings being something which 11 we were told actually originated within the surgical 12 practice of NHS hospitals and then spread more widely as 13 being a sort of recognised means by which issues which 14 have arisen would be discussed amongst professionals to 15 try to either deal with problems that had come up or try 16 to avoid problems going forward. Is there a similar 17 model to that within the private system, given the 18 practical limitations around how much time a consultant 19 would spend there? 20 A. Yes, we do have such governance models. They focus in 21 two different areas and if it would be helpful, 22 I'm happy to explain them. 23 Q. That would be helpful, yes. 24 A. We have, at every hospital, a medical advisory 25 committee. In the current system that is now chaired by Page 112

1 what we term a clinical chair. Previously that would be 2 the medical advisory committee chair. That committee 3 also involves the executive director at the hospital, 4 the director of clinical services who would be the 5 senior nurse in the hospital. And that committee 6 oversees governance matters particularly relating to the 7 medical profession in terms of outcomes, readmission 8 rates and other parameters that we may want to look at 9 to look at performance. 10 Q. So would obligations or practices related to the subject 11 I was talking about earlier, discussing matters with 12 colleagues or discussing issues that have arisen with 13 patients, would that system exist as between 14 a consultant and the individuals whom you've recognised 15 on the medical advisory committee, the executive 16 director, the director of executive services, as opposed 17 to with other professionals in the same field, or is 18 there a system for that as well? 19 A. No, there is also systems for that within specialties 20 where we operate a very similar model to that account 21 that you've mentioned in mortality and morbidity review. 22 More developed in some specialties than others but 23 definitely exists within the independent sector 24 providers. 25 Q. Because we'll come on to the information you've been Page 113	1 medical advisory committee with the executive director 2 on a two-yearly basis. 3 Q. Thank you. So there was a process whereby every 4 two years, the medical advisory committee would 5 effectively reassess in our case Mr Eljamel's ability to 6 have his practising privileges, is that right? 7 A. That is the information that we've gleaned from the 8 documents that we have located. I have no direct 9 knowledge of that at Fernbrae, having never worked 10 there. 11 Q. Of course. Well, let's explain a little bit of the 12 context in which you've come to provide this information 13 helpfully to us. Could we look, please, at 14 paragraph 4.1 of the report. And you explain, I think, 15 in this section how it came to be that Circle Health 16 Group, which is the organisation of which you are 17 a part, came to acquire responsibility, I think, for 18 a company that had responsibility for the operation of 19 Fernbrae Hospital in Dundee is that correct? 20 A. That is correct and clearly a hospital that we never 21 operationally managed as Circle Health Group. 22 Q. Yes, indeed. So the position, I think, to summarise -- 23 if I have got this wrong, please correct me -- is that 24 the hospital was operated over the period in which we 25 are interested by a different organisation called BMI; Page 115
1 able to unearth about Mr Eljamel's practice within the 2 Fernbrae Hospital in Dundee, but broadly speaking, over 3 the period he was there, there was only one other 4 consultant neurosurgeon who appears to have carried out 5 very, very few surgeries in the hospital. And 6 therefore, to some extent, over the period during which 7 he operated at that hospital, he really was the 8 neurosurgical service. So therefore, by practical 9 limitation, there would be a limitation on his ability 10 to discuss that with his peers, if you like? 11 A. Yes, I accept that. 12 Q. But, as you've explained to us, would systems have 13 existed at that time for similar aspects of professional 14 governance, discussion, sharing issues, adverse events 15 reporting, exist with regard to the systems that you've 16 set out, the medical advisory committee and other 17 in-house professionals? 18 A. The documentation we were able to find in our searches 19 and that we've submitted to the Inquiry confirm that the 20 medical advisory committee constitution included 21 requirement to check governance parameters for 22 consultants on a regular basis, at least once every 23 six months, and that those consultants were subject to 24 bi-annual review. By that, I mean that the granting of 25 ongoing practising privileges was assessed by the Page 114	1 is that correct? 2 A. That is correct. 3 Q. And subsequently, long after Mr Eljamel had stopped 4 operating there, Circle effectively acquired BMI? 5 A. That's correct. 6 Q. And therefore acquired, if you like, legal 7 responsibility for what BMI had or had not done before, 8 during the course of its operation of that hospital? 9 A. That is correct. 10 Q. So therefore, you worked for an organisation called 11 Circle Healthcare and as you have pointed out, Circle 12 Healthcare never actually operated Fernbrae Hospital at 13 all? 14 A. That is correct. 15 Q. And the hospital itself, I think you tell us at 16 paragraph 4.2, closed in April 2019? 17 A. That is the information that we gleaned, yeah. 18 Q. Yes. So what you've done, in order to try to assist the 19 Inquiry with these questions and in line with your 20 organisation's inherited responsibility, if you like, 21 for what went before, is you've tried to look through 22 your archives and paperwork that might be available to 23 you from the takeover of BMI and you've tried to help us 24 with the questions that we've asked you, is that right? 25 A. That is correct. Page 116

1 Q. But there are no people who work for Circle Healthcare 2 who had any direct involvement with any of the services 3 provided at Fernbrae? 4 A. There are no people working in the organisation with 5 direct involvement. We have pointed out, I think in the 6 statement, two individuals who worked for BMI at the 7 time but not directly related to Fernbrae. 8 Q. Yes, thank you very much. And you understand, I think, 9 that Mr Eljamel had practising privileges at the 10 hospital between 2002 and 2013; is that correct? 11 A. That is our understanding, correct. 12 Q. Yes. Could I just ask you, in general terms as far as 13 the practising privileges are concerned, how specific 14 the practising privileges would be for an individual 15 consultant surgeon offering services through a private 16 hospital? Would they specify that one could offer, for 17 example, neurosurgical services or would it specify 18 something more specific in terms of the types of 19 procedures, or something in between? 20 A. I can answer that, if helpful, from my own personal 21 experience of applying for practising privileges with 22 BMI in and around this time. The process was a -- you 23 would submit an application to the hospital director. 24 You would then have a meeting with the hospital 25 director. As the consultant, you had to supply a level Page 117	1 The ultimate responsibility for granting does rest 2 with the executive director as registered manager of the 3 hospital. 4 Q. Right, and is it the case that a consultant is entitled, 5 if offered the practising privileges, if you like, to be 6 able to conduct the medical procedures included within 7 the ambit granted and nothing beyond; is that correct? 8 A. That is correct and that is how the practising 9 privileges process should work and that then is why we 10 have a scope of practice within that documentation and 11 requirement that's also reviewed by the medical advisory 12 committee. 13 Q. Because to some extent, I would imagine, given that 14 private hospitals are part of private businesses, there 15 is a decision to be made as to what services that 16 particular hospital wishes to offer based on 17 a commercial assessment of what will be in demand in the 18 area, presumably? 19 A. Yes, the decision on the type of services as 20 a hospital -- one a private hospital provides will 21 depend on a number of factors. The commercial element 22 of a service is clearly one consideration but not 23 necessarily the overriding consideration. Judgments are 24 also made on the level of acuity, ie the level of 25 complexity of care that a hospital can deal with and by Page 119
1 of information and confirmation of qualification and as 2 a bare minimum, that was your GMC registration and 3 confirmation that you were on the specialist register of 4 the GMC for the specialty that you were planning to 5 undertake in that hospital. 6 You have to supply evidence of medical indemnity. 7 You have to supply evidence of appraisal. You have to 8 supply evidence of scope of practice and by that, I mean 9 the procedures that you undertake in your NHS practice, 10 the volume of procedures that you undertake and your 11 experience. Clearly, there are occupational health 12 requirements as well that you have to abide by and then 13 the hospital executive director will ask for a reference 14 and that usually is from a line manager in your NHS 15 hospital. That could be the responsible officer, 16 probably more likely your clinical director. 17 Once that information is collated, that is discussed 18 with the medical advisory committee. Many of those 19 medical advisory committee members will be working in 20 the same hospital that you are working in as the 21 consultant applicant. Your application is discussed and 22 assessed and if the MAC do not raise any concerns, then 23 they agree with the executive director this is 24 a suitable individual to be granted practising 25 privileges. Page 118	1 that, I mean the number of operating theatres, is there 2 access to an Intensive Care Unit, the services provided 3 at a local NHS hospital and how can they be mirrored? 4 So I think the granting is a little -- it's 5 multi-factorial not purely commercial. 6 Q. I see. 7 THE CHAIR: Is there a notional maximum number of 8 consultants to whom a particular hospital might confer 9 these privileges? One imagines obviously time, space 10 and theatres are finite but equally, by the nature of 11 the arrangement you're describing, it doesn't follow you 12 can have no more than one a day, I don't know. How does 13 it work? 14 A. So there is -- again, the local hospital directors make 15 those judgments. It's based on clinical availability 16 within the hospital and that would be outpatient clinic 17 space, operating theatre capacity. Within that as well, 18 an element of succession planning so that you can 19 maintain the service, accepting that there may be 20 a start-up period where a consultant is a bit quieter 21 but that individual is setting up a practice to be able 22 to take over, to keep services going and viable in the 23 hospital. 24 THE CHAIR: Understood. Thank you. 25 MR DAWSON: And in the searches which you have undertaken Page 120

1 through the documents to which you have access, have you 2 been able to ascertain what practising privileges you 3 think that Mr Eljamel had within the hospital? 4 A. We clearly have found, in the documents that we have 5 submitted, the list of requirements and the relevant 6 practising privileges policy from around the time that 7 Eljamel worked at Fernbrae. As we have pointed out in 8 the statement, however, the paper -- what we believe to 9 be paper practising privileges files were stored at 10 local hospital. They were retrieved but a number of 11 practising privileges files were not within the storage 12 box which Circle Health Group received and 13 unfortunately, Eljamel's is one of those. 14 Q. I see. So, insofar as you have helped us in the 15 statement with understanding what you think his 16 practising privileges to have been, is that a process of 17 you trying to deduce that from what information is 18 available? 19 A. We have submitted the requirements for granting of 20 practising privileges at the start of Eljamel's working 21 time with BMI at Fernbrae Hospital. Unfortunately, we 22 have not been able to corroborate that with Eljamel's 23 file for reasons Circle Health Group can't explain but 24 that file was not within the storage boxes retrieved. 25 Q. I see. And what is your impression of the extent of the Page 121	1 a combination of what you would expect that hospital to 2 be able to offer within the confines that you've just 3 helpfully set out, but also within the information that 4 you have been able to look at, that effectively his 5 practising privileges would have covered low to moderate 6 complexity spinal surgery. Is that a correct 7 impression? 8 A. That is our understanding and that is our impression. 9 Q. And if there were surgeries that were done by him over 10 and above that broad categorisation, is the correct 11 inference to take from the information that you have, 12 based on your experience of how these hospitals operate, 13 that surgeries, if they were undertaken beyond that 14 broad category, would not have been within his 15 practising privileges? 16 A. I think that any deviation from that type of surgery in 17 that hospital, I would personally expect as Chief 18 Medical Officer now that that would be questioned by the 19 local hospital and escalated for discussion before that 20 type of surgery was allowed to be undertaken in a low 21 acuity hospital like Fernbrae. 22 Q. When you say "low acuity" could you just help us with 23 broadly what that concept means? 24 A. Apologies. 25 Q. Not at all. Page 123
1 practising privileges that he had? 2 A. So we have submitted the clinical workload that he 3 undertook in the 11-year period. From memory, it was 4 488 procedures undertaken in that period. That, in the 5 independent sector, is a relatively modest private 6 practice. The procedures performed were predominantly 7 low to moderate complexity spinal procedures. I'm not 8 a spinal surgeon and cannot give expert opinion beyond 9 that, but that is my understanding of his practice at 10 Fernbrae Hospital. 11 Q. Would he have been allowed to offer other neurosurgeries 12 beyond the broad definition you've given there? 13 A. That is something, again, that I can't directly comment 14 on having never worked or been part of 15 Fernbrae Hospital. I can give a general view, however, 16 through my experience as a clinician, that undertaking 17 complex cranial neurosurgery in a hospital without 18 intensive care and facilities would be potentially 19 problematic. 20 Q. Yes, because I think we understand from other evidence 21 that Mr Eljamel had a broad neurosurgical practice which 22 covered intracranial surgery, spinal surgery and indeed, 23 a significant amount of functional neurosurgery. And 24 the impression from your statement, as you've helpfully 25 defined it, is that you would have expected, I think, Page 122	1 A. What I mean is a hospital without the ability to 2 escalate patient support into a facility such as a high 3 dependency unit, an Intensive Care Unit, or to 4 a facility where you can give enhanced care which may be 5 required if you undertake more complex surgeries. 6 Q. Because I think it's important to understand that it 7 would be wrong, I think, to assume if Mr Eljamel's 8 practising privileges did not extend outwith that area, 9 that it would, in some way, reflect someone's view that 10 he was incapable of performing those surgeries. It's 11 based mostly on what the hospital can safely deliver, is 12 that right? 13 A. That's right, yes. 14 Q. And also, to an extent, as you said already, although 15 it's not the only consideration, based on commercial 16 decisions about what services it thinks the local 17 population will wish to avail themselves of? 18 A. Yes, equally correct. 19 Q. Yes, and the reason why, from a neurosurgical 20 perspective in broad terms, the practising privileges 21 would likely to be restricted to these low to moderate 22 complexity spinal surgeries would be a combination of 23 the demand for those surgeries in the wider population 24 and also, as you have said, the fact that more 25 complicated surgeries would effectively be deemed too Page 124

1 risky to undertake in an hospital of that nature with 2 limited, for example, high dependency -- no high 3 dependency facility available? 4 A. That's correct. 5 Q. Thank you. Could I ask you please to look at a document 6 you've helpfully provided to us -- 7 THE CHAIR: Can I clarify. Sorry, Mr Dawson. The position, 8 as you understand it at Fernbrae, was not that there was 9 limited high dependency provision, there was none at 10 all? 11 A. That is my understanding. My understanding is 14 beds 12 and one operating theatre and no high dependency or 13 Intensive Care Unit. 14 THE CHAIR: Yes, thank you. 15 MR DAWSON: Could I ask you please to have a look at 16 a document, it's CHG-00248. 17 Just zoom in a bit. It's extremely difficult to 18 pick up some of these words even zoomed in. I wonder 19 whether you could help us with what this document is? 20 In particular, if one could look at page 1, tell us what 21 this is depicting? 22 A. This document is predicting, by year, the operations 23 undertaken by Professor Eljamel and frequency of those 24 operations based on appropriate coding. The "C" number 25 at the front is Eljamel's GMC number. These are billing Page 125	1 A. That is the last date that we have record of surgery and 2 we have also submitted theatre logs post that date 3 which, again, confirm that there were no surgeries by 4 Eljamel post June 2013. 5 Q. Thank you very much indeed. And if one looks at page 8 6 of this document onwards, this runs on for many, many 7 pages. Could you tell us what is included in the rest 8 of this bundle? This is just a snapshot of what it 9 contains. 10 A. So this, again, is a cumulative number of the different 11 procedures. My understanding of this document, we also 12 delineate whether -- what we would term the "payor 13 group". So there are a section within this as well that 14 looks at NHS activity for Eljamel which we found no NHS 15 activity undertaken at Fernbrae Hospital for that 16 treating surgeon. 17 Q. So what that means, I think, is that none of the 18 patients who were treated by Mr Eljamel at 19 Fernbrae Hospital were NHS patients in the sense that 20 they were patients who were being effectively paid for 21 by the NHS to be operated on there; is that correct? 22 A. That is correct. That is the information we have found, 23 that all of his patients were either self-funding 24 through the private sector or had private medical 25 insurance to fund the treatment that they received. Page 127
1 codes which then link to procedure which then lead to 2 numbers per year from 2005, as far as I can see, to 3 2013. 4 Q. Okay. And then, if one jumps ahead to page 3 of the 5 document, is this then effectively rather than the 6 procedures listed by type of procedure and number, 7 a full list of all of the procedures which were 8 undertaken by him? 9 A. That is the individualised -- yeah, patient number, 10 procedure. So this is the data that gives that 11 overview, this is the data that sits behind it, to build 12 up those numbers that we presented on the last slide. 13 Q. Yes, I understand. So whereas on page 1, we saw, 14 against each procedure, varying numbers depending on the 15 number of surgeries that he would offer, down the 16 right-hand side here, we just have one because this is 17 a sort of itemised list of all of the different 18 procedures? 19 A. Exactly. 20 Q. Indeed, this, I think, is chronological. If you look at 21 the top, it starts 7 January 2003 and it runs over 22 a number of pages and if you look at page 7, down to the 23 bottom, please. There is an entry there dated 24 19 June 2013 which I think could be last surgery that 25 you have a record of; is that right? Page 126	1 Q. Understood. But that shouldn't be understood, as 2 I understand it, as excluding the possibility of what -- 3 this is a term that we use within the Inquiry, of what 4 we might describe as a "hybrid patient", who may have 5 received some of their neurosurgical care in private 6 care and some of their neurosurgical care in Ninewells 7 in Dundee? There could be patients of that nature who 8 received some care in each setting, if you like; is that 9 right? 10 A. There could be. That would be an area that, in the 11 independent sector, we couldn't track because the notes 12 are completely separate and we do not have access to NHS 13 documentation. 14 Q. Yes. I'm just trying to be clear that it wouldn't 15 exclude the possibility that such patients, who may have 16 received other neurosurgical care in the NHS, were 17 included within these statistics. What we can say 18 though is that they were either self-funding or being 19 covered by insurance to have those procedures done in 20 Fernbrae? 21 A. That's correct. 22 Q. Thank you. So, is it correct then from page 8 onwards 23 that what we have there, is a list of -- is it a list of 24 all of the procedures carried out in the hospital? 25 A. I believe so, as that is not segmented to an individual Page 128

1 surgeon. 2 Q. Because, for example -- there are a number of -- there 3 are a wide variety of different types of surgeries in 4 this document between page 8 and page 92 which is the 5 last, some of which are, for example, gynaecological 6 operations. This doesn't tend to suggest Mr Eljamel 7 carried out any of those, does it? 8 A. No, it doesn't. 9 Q. But this is just giving us an indication as to the 10 variety of surgeries that would be offered within 11 Fernbrae and in connection with which, someone would 12 have practising privileges in the hospital, is that 13 right? 14 A. That's correct. 15 Q. So if we could go back then to the first page of this 16 document which was the summary of the number of 17 different surgeries that were offered by him. Can you 18 help us with the -- a number of these surgeries have 19 different codes at the beginning? 20 THE CHAIR: Sorry, Mr Dawson. Can I just check that 21 everybody can read that all right? I think we might 22 need to do some enhancement as part of generality. 23 MR DAWSON: If we could try to. It's even worse when one 24 tries to look at it in some formats. If you can see, 25 down the left-hand side in the middle column, there are Page 129	1 nerves of the central nervous system. That is -- beyond 2 that, it's very difficult to understand what area this 3 was done, but "repair of dura" we are aware has been 4 performed particularly around spinal nerve routes 5 when -- if they are injured during a spinal procedure. 6 Q. That could also refer to the dura around the brain? 7 A. It could. 8 Q. Is it likely, do you think, that that's a spinal surgery 9 or a brain surgery, in the circumstances you've 10 described, of the types of surgeries that would be 11 offered in this hospital? 12 A. Again, I have no direct knowledge that allows me to give 13 an opinion on that, but would suggest this is more 14 likely spinal given the nature of the hospital in which 15 he worked. 16 Q. Four further down, there's another type of surgery which 17 says "insertion of spinal nerve stimulator". Could you, 18 again based on your broad medical knowledge, tell us 19 broadly what that involves? 20 A. A spinal nerve stimulator is an electronic device, 21 a little bit -- you can think of it a little bit like 22 a pacemaker, I would think, that's put in 23 subcutaneously. It sits adjacent to the spine. The 24 nature of that is to stimulate the spine and it is 25 a recognised treatment for chronic pain and chronic back Page 131
1 a number of codes attached to the different types of 2 surgeries. Is that -- I take that to be a sort of 3 internal code within BMI or Fernbrae as to a particular 4 type of surgery, is that right? 5 A. That is my inference, that that would be 6 a charge/billing code. 7 Q. I see. And so a number of the codes, not all of them 8 but a number of the codes begin "CEN". Is there any 9 significance to that? 10 A. I'm not aware of any significance to that, I'm sorry. 11 Q. Okay. And one can see, for example at the bottom, in 12 the bottom six rows, the particular types of billing 13 codes used there do not start "CEN", they start either 14 "HEN" or "OR". Are you aware of what those different 15 the use of those different letters would mean? 16 A. I don't know fully, I'm afraid, but coding systems for 17 this often have a mixture of a different way of 18 representing them, just for the complex -- just to 19 recognise the complexity and the number of different 20 codes that you can actually create. 21 Q. Thank you. In this list, six from the top there is 22 an entry which starts "CE3420", "repair of dura". Could 23 you help us, based on your general medical knowledge, 24 what that type of operation is? 25 A. So the dura is part of the lining that sits around the Page 130	1 pain and other such pathologies. 2 Q. Thank you. About halfway -- just below halfway down, 3 there is a reference to a "trigeminal ganglion 4 injection" under local anaesthetic. Do you see that, 5 "trigeminal ganglion injection"? 6 A. I do. 7 Q. Again, could you help us broadly with what that is? 8 A. The trigeminal ganglion is one of the cranial nerves and 9 again, you can get facial pain from trigeminal 10 neuralgia. One of the treatments is to inject, usually 11 under X-ray control, around that with local anaesthetic. 12 Q. Below that, "trigeminal ganglion radiofrequency lesion", 13 or something like that; is that right? 14 A. That is. Again, my -- limited knowledge as I'm not 15 a neurosurgeon, but it's a very similar procedure 16 except, instead of just injecting local anaesthetic plus 17 or minus steroid which is the common way, 18 a radiofrequency lesion is a device that oblates that 19 ganglion more permanently. Again, with the aim of 20 creating symptomatic relief. 21 Q. And there are various references to some sort of "carpal 22 tunnel syndrome" or "carpal tunnel release". Could you 23 help us, broadly again if you could, what that's to do 24 with? 25 A. Carpal tunnel syndrome entrapment of the median nerve at Page 132

1 the wrist and is dealt with by surgical release of that 2 by division of what we call the carpal ligament, to 3 decompress the nerve. 4 Q. So that would be the sort of thing that neurosurgeons 5 might do in the peripheral neurosurgical system rather 6 than the spinal area, is that right? 7 A. Yes and that has a big overlap with other specialties 8 such as orthopaedics, upper limb surgeons and other -- 9 Q. Thank you very much. You provided -- again, helpful -- 10 we can put that to one side now. You have provided us 11 with a helpful analysis of information that we had about 12 the amount of surgeries that Mr Eljamel did over the 13 period and a kind of breakdown of that, in particular in 14 comparison with other surgeons. I have touched upon 15 this already, but if we could go -- just bear with me 16 for two seconds -- to paragraph 3.7 please of the report 17 statement. You say there: 18 "I believe the neurosurgery service at BMI Fernbrae 19 was small in terms of patient and procedure numbers and, 20 in terms of consultants with [practising privileges] 21 providing neurosurgical procedures, data extrapolated 22 from a revenue database (known as 'TM1') ... shows 23 activity data for BMI Fernbrae between 2005 and 2019 24 (when the Hospital closed), broken down by specialty and 25 consultant. From this, it can be seen that the Page 133	1 a year will be significant -- or higher than the number 2 undertaken by Mr Eljamel -- by Eljamel. 3 Q. So for the reasons we've discussed, commercial reasons, 4 availability, all that sort of thing, there are -- it is 5 basically a small hospital, certainly in the sense of 6 offering a small neurosurgical service, is that right? 7 A. That's right. 8 Q. Could we have a look, please, at scroll down to 9 paragraph -- sorry, just before we go on to that. The 10 position, I think, is that from what you've said there, 11 there was one other neurosurgeon working there in the 12 period when Mr Eljamel was, which was between 2002 and 13 2013, a Dr O'Riordan; is that right? 14 A. We understand so, yes. 15 Q. And from the material that you've seen, there was 16 another doctor who joined the service but -- that was 17 a Mr Demetriades, but he joined in 2014 which, I think, 18 was after Mr Eljamel did his last surgery, as we saw 19 from the documentation; is that right? 20 A. That is correct. 21 Q. Could we look then, please, at paragraph 3.8, just 22 scrolling down a bit further from where we are, you say: 23 "As is confirmed by this data set ... Mr Eljamel was 24 one of the surgeons who performed neurosurgical 25 procedures at BMI Fernbrae. Our records indicate that Page 135
1 neurosurgery service activity is modest and, until 2013 2 was delivered primarily by Mr Eljamel, with a smaller 3 service offered by Dr O'Riordan. Thereafter, 4 [Mr] Demetriades joined the service and his clinical 5 activity is listed from 2014 to the point of closure of 6 the hospital. The data tab regarding funding suggests 7 there were no NHS funded patients receiving 8 neurosurgical procedures at BMI Fernbrae in the 9 (abridged) relevant period 2002 to 2013, and therefore 10 none treated by Mr Eljamel." 11 As you've already told us: 12 "The revenue database (TM1) does not provide any 13 data for BMI Fernbrae pre-2005. Unfortunately, and for 14 the reasons explained in my response to question 6 later 15 in this statement, where CHG has been able to access 16 legacy systems, it has not always been possible to 17 locate or retrieve a complete set of data from those 18 systems." 19 So, in relation to the size and volume of 20 neurosurgery provided, you describe this as "modest" 21 your statement. Why do you say that? 22 A. Basically, that is based on a comparative assessment of 23 the neurosurgical service relative to what we would 24 expect in a similar sized hospital for other 25 specialties, where the number of procedures within Page 134	1 Mr Eljamel had practising privileges at BMI Fernbrae for 2 a period of 11 years running from December 2002 to early 3 January 2014 (although the data indicates that 4 Mr Eljamel did not perform any procedures or complete 5 any clinics at BMI Fernbrae from June 2013 onwards, and 6 therefore his clinical practise at Fernbrae can be 7 regarded as concluding as at June 2013). A separate 8 data set to the TM1 data referred to at paragraph 3.7 9 above, taken from Ultragenda (patient booking system), 10 provides details of procedures performed by Mr Eljamel 11 from 2003. I have exhibited this data confirming the 12 dates, numbers and nature of surgeries performed by 13 Mr Eljamel over that period ... This indicates that 14 Mr Eljamel performed 483 procedures at BMI Fernbrae over 15 the period he held practising privileges and maintained 16 a clinical practise (December 2002 to June 2013). It 17 further indicates that Mr Eljamel performed 40 different 18 procedure types at BMI Fernbrae, the most frequent being 19 lower complexity spinal ..." 20 And in the box below that, you produce information 21 about some of the most frequent. 138 entries were 22 "posterior excision of disc prolapse", is that right? 23 A. That's correct. 24 Q. 77 anterior excision of disc or discs with fusion; is 25 that correct? Page 136

1 A. That's correct. 2 Q. 60 were something I was going to ask you about, which 3 appears quite often, an "X-stop procedure". Can you 4 tell us what that is? 5 A. I'm afraid that's where I am struggling a little bit 6 with my spinal knowledge. My understanding, from 7 reading around, is the X-stop procedure is a distraction 8 technique used in the spine. The indications for it and 9 other matters relating to it, I am afraid I can't 10 comment beyond what I have already stated. 11 Q. I see. So, we appear to have a total number of 12 483 procedures over a period of around ten and 13 a half years, is that right? 14 A. That is the data that we found, yes. 15 Q. Yes, and is it correct to say, from the information that 16 you've just -- in the statement that I have just read 17 out, that you were effectively working from two 18 different systems were you, to try to work out the 19 answer to that question? 20 A. Yes, because of the historic nature of the search and 21 the complexity associated with the change of ownership 22 and change in systems that had happened during the 23 period of BMI's ownership. TM1 is a billing database so 24 we were able to get the 2005 onwards data from that. 25 Ultragenda, more an appointment management database Page 137	1 we work on an average, that looks around about one 2 surgery a week, is that fair? 3 A. That's fair, give or take. 4 Q. I think it's a bit less than that, but if one takes into 5 account holidays and things like that, it looks like 6 about one surgery a week? 7 A. Yeah. 8 Q. So you've mentioned there that that might equate, in 9 real terms, to one operating session a week and one 10 clinic; is that right? 11 A. That is my expectation from this work and it may be less 12 frequent than that. We don't have that level of detail 13 in the searches. 14 Q. Okay, and when you say "a clinic", what does that mean? 15 A. So the outpatient clinic is where a consultant would see 16 new patients who have been referred, either 17 self-referred or via their GP, for an assessment of 18 a neurological problem by the consultant. That might 19 then lead to investigations, it may also lead to repeat 20 outpatient visits to discuss the investigations and plan 21 a treatment protocol. Also the outpatient clinic allows 22 patients to be reviewed if you've had a procedure, so it 23 is standard practice that when you've had an operative 24 intervention, certainly a spinal intervention or 25 similar, that you would be reviewed at least once by Page 139
1 which we were able to get the 2003 onwards data. The 2 team did due diligence to try and ensure there were no 3 duplications and the two systems were matched. 4 Q. Okay. 5 THE CHAIR: Mr Dawson, just one quick point of detail. In 6 terms of the accessibility of the hospital to somebody 7 like Mr Eljamel with his practising privileges and 8 trying to put some colour to what significance one might 9 attach to 483 procedures over a period of time, would it 10 be wrong to assume, or right to assume, that an NHS 11 consultant with privileges of this kind would have -- 12 would be doing one procedure a day, or can it be 13 arranged such that he could see multiple patients in any 14 given day, depending on the availability obviously of 15 the theatre? 16 A. The usual working pattern for a consultant such as 17 Eljamel working in the private sector would be that that 18 individual consultant will have some fixed sessions 19 within the hospital. With this volume, I would expect 20 one clinic per week and at most one operating list per 21 week, given the low volume number of procedures. 22 THE CHAIR: That's helpful. Thank you. 23 MR DAWSON: So if we work on the basis that, certainly on 24 average -- and we've got all the data there to work out 25 precisely when these surgeries were being done -- but if Page 138	1 your treating surgeon to ensure that your recovery is as 2 expected. 3 Q. I see, that's helpful. So it would be wrong to assume, 4 when looking at this big list of surgeries, that what 5 Mr Eljamel was doing at Fernbrae was just surgery? 6 A. Yes, the normal practice would be an outpatient service, 7 a clinic service where you are assessing, advising, 8 diagnosing and managing patients without operative 9 intervention. That clinic then -- a small percentage of 10 that clinic with proceed to a surgical procedure. 11 Those patients, post-discharge, will then go back to 12 the outpatient clinic for ongoing assessment until 13 discharge, provided they make a recovery. 14 Q. So when you say that a small percentage would proceed to 15 the operations, the statistics tend to suggest it's 16 about one operation a week, but if it's only a small 17 percentage that get to the operation, would he be 18 conducting a number of interviews with potential 19 patients in an outpatient clinic a week on average? 20 A. Again, I don't think I've seen that data specifically 21 laid out from an outpatient perspective but would you 22 expect most surgeons in private practice to run 23 a regular outpatient clinic, the size of which, in the 24 independent sector, is variable and much less consistent 25 than it is in the NHS, driven by demand. Page 140

1 Q. I see. So would that normally take place at the same 2 time as the operative session, on the same day, or would 3 it tend to be a separate day or is that dependent on the 4 individual consultant's preference or availability of 5 theatre or whatever? 6 A. It depends on a number of factors. Facility 7 availability within the independent sector and of course 8 the consultant's job plan and commitments in the 9 National Health Service, remembering that that private 10 work should be delivered at separate times to NHS 11 commitments. 12 Q. And I think you also mention, just in terms of what 13 would be typical, is if you do have a patient you see in 14 the outpatient clinic whose case looks like the 15 consultant might be able to do something to help with, 16 you mentioned the possibility of there being, I think, 17 a number of further consultations. For example, I think 18 you mentioned to discuss the possibility of the outcome 19 of investigations or something like that. Is that the 20 way that the system generally works? 21 A. Generally. It depends on the presenting condition and 22 the complexity of the diagnosis and will also depend on 23 whether or not an individual patient has had 24 investigations prior to the consultation that means 25 a decision can be made at the first attendance. In the Page 141	1 Q. Okay. And if it were the view of the consultant that 2 such a scan were merited in the circumstances, within 3 the private hospital setting, how would he go about 4 getting such a scan? 5 A. So many private hospitals have our own MRI scanners and 6 that is increasingly common now. Clearly, I don't 7 believe Fernbrae Hospital had that but where that the 8 case, private hospitals usually had arrangements with 9 the local NHS hospital for provision of private scanning 10 facilities. Again, I don't know if that was the case at 11 Fernbrae but that is certainly the way that access to 12 MRI scanners and sophisticated investigations in the 13 past would have worked between the independent sector 14 provider and a local NHS trust. 15 Q. And so if, in that scenario where the consultant did 16 wish further investigation such as scanning be 17 undertaken, a further appointment will be taken with the 18 patient to have the scan done, presumably? 19 A. That's correct. 20 Q. And then the results would be sent through to the 21 consultant who would consider those and then there would 22 be, presumably, another consultation at which the 23 outcome and possible treatment options would be 24 discussed? 25 A. That would be my experience and expectation as Page 143
1 majority of the time the treating consultant will 2 usually want to undertake their own investigations in 3 order to arrive at a treatment plan that they can 4 discuss with the patient before proceeding to any 5 surgical intervention or procedural intervention. 6 Q. So just to look at that, in broad terms again, in the 7 sort of scenario one might face in a neurosurgical 8 setting, in particular in relation to the spinal 9 surgeries that we've seen Mr Eljamel was mostly doing at 10 Fernbrae, it may be that a patient would arrive, for 11 example, already having had a scan done indicating 12 a particular problem with their spine, it may be? 13 A. May be, yeah. 14 Q. But you mentioned there that it would be normal for 15 a surgeon to want to get their own investigation, so 16 there might be a further scan undertaken to ascertain 17 further information? 18 A. Not necessarily. If the original scan is recent, is of 19 good quality and the finding on the scan matches the 20 symptoms and clinical signs the patient has, then 21 a decision could be made from that one scan. Clearly, 22 if an individual arrives without any previous scans the 23 likelihood is the consultant will order a scan in order 24 to confirm his or her working diagnosis before 25 proceeding to surgical treatment. Page 142	1 a consultant, yes. 2 Q. Okay. So far as the delivery of surgeries is concerned 3 within the private setting, you mention in your 4 statement -- and I think we've touched on already -- 5 that there is no training expectation as there would be 6 in the NHS, within private hospitals; is that correct? 7 A. That is correct. 8 Q. So I think maybe you used the phrase "consultant-led 9 service" or something like that, but effectively it's 10 consultants that are offering service through 11 Fernbrae Hospital, is that right? 12 A. That's right. 13 Q. So Mr Eljamel was one of those and there would be others 14 in different disciplines and we've spoken about two 15 others in his field? 16 A. That's correct. 17 Q. So effectively if one wishes to have a private 18 operation, one is choosing to have that done by 19 a consultant? 20 A. That is correct. 21 Q. So there's not an option, as there would be for example 22 in an NHS hospital, for Mr Eljamel or another consultant 23 to decide that a particular surgery could be undertaken 24 by a more junior surgeon, in particular at times in 25 accordance with that consultant surgeon's obligations to Page 144

1 train the junior? That doesn't happen in private 2 hospitals, is that right? 3 A. That is not normal practice in private hospitals, no. 4 Q. So if you're paying the money, you're paying for the 5 consultant, effectively? 6 A. That's correct. 7 Q. So as far as intraoperative procedures are concerned, if 8 there was a requirement for there to be assistance of 9 the consultant, by whom would that assistance be 10 provided, not just in the surgery itself but with all of 11 the other aspects that one has involved in a surgery and 12 possible complications? 13 A. There are two basic models by which a surgeon operating 14 in the independent sector gets appropriate assistance 15 for the surgical procedure. Clearly, the anaesthetist 16 will obviously look after the management of the 17 anaesthetic. There will be a full theatre team in the 18 operating theatre. One of those theatre team will be 19 what is termed the scrub nurse. And the scrub nurse 20 role is to manage the instruments and manage the theatre 21 discipline and the theatre process. The surgeon will 22 then operate, but for many procedures requires what we 23 term "a first assistant". That assistant really is 24 working under the direct supervision of the consultant 25 and is offering help in the form of what we would term Page 145	1 private hospitals, to keep medical notes of the 2 procedures which have been undertaken? 3 A. There is clearly an obligation for all hospital 4 providers to have contemporaneous medical records. That 5 is a regulatory requirement of all hospitals. We are 6 responsible, in terms of a regulatory pattern, for the 7 care delivered in all of our hospitals. So that would 8 be standard practice and I would expect that would have 9 happened at Fernbrae. 10 Q. So with -- I think the position is that you do retain 11 access to certain medical notes, patient medical notes, 12 is that right? 13 A. That's right. 14 Q. And you've provided some copies of those to the Inquiry 15 before now? 16 A. Yes, we have. 17 Q. In particular -- this is really for the information of 18 people -- those have been provided in connection with 19 applications made to the Independent Clinical Review, 20 which is an associated process to the Inquiry, which not 21 only provides clinical reviews of NHS patients but also 22 of private patients, and it's the Inquiry that's 23 responsible for recovering those records. So we've gone 24 through that process with your company, haven't we, 25 asking for some medical records? Page 147
1 "retraction", holding retractors to keep things out of 2 the way to give the surgeon sight of -- yes, line of 3 sight to the operative procedure. 4 Q. Can I just stop you there. The first assistant and the 5 scrub nurse that you've mentioned so far, are they 6 employees of the company running the private hospital? 7 A. The scrub nurse will always be an employee of the 8 private hospital. The first assistant, there are two -- 9 there were, at that time -- and I know from my own 10 experience as a surgeon working in the independent 11 sector -- two models. The first model was that the 12 hospital would provide an advanced trained nurse, 13 a specially trained scrub nurse with extra qualification 14 to be a surgical first assistant. So it would, again, 15 be a member of our staff who would have assisted in that 16 instance. 17 The other option, which was commonly used in around 18 this time, was that the operating surgeon would bring 19 a doctor who he or she works with in the NHS to act as 20 that first assistant under the direct supervision of the 21 consultant. 22 Q. Do we know what model Mr Eljamel used from the 23 documentation available? 24 A. I'm afraid, we don't. 25 Q. And to what extent would there be an obligation, within Page 146	1 A. That's correct. 2 Q. And would it be expected that the question I asked 3 a moment ago as to which model as to first assistant was 4 followed, would be evident from those records because 5 there would be entries there showing who was in 6 surgeries and if, for example, there were certain people 7 there regularly, they'd be identified as either "scrub 8 nurse acting as first assistant" or someone that 9 Mr Eljamel had brought with him to assist? 10 A. I would suggest that that would be best practice 11 record-keeping documentation, to note the relevant 12 people who were present at the operation in your 13 documented operation note, yes. 14 Q. But the question as to which practice was followed by 15 Mr Eljamel is not evident from the perhaps more 16 administrative records that you've been looking at, is 17 that right? 18 A. That's right. 19 Q. Are theatre logbooks kept in the private sector? 20 A. Yes, theatre logbooks are kept in a similar way to those 21 of the NHS. 22 Q. And have you managed to locate any theatre logbooks 23 relating to any of Mr Eljamel's surgeries within the 24 suite of documentation available to you now? 25 A. I haven't seen any theatre logbooks which relate to Page 148

1 Mr -- to Eljamel. We have supplied the logbook from 2 when he finished. 3 Q. Thank you. Could I have a look, please, back at the 4 statement then, in particular at paragraph 24.1.1. Now, 5 at this point as I understand it, you're providing 6 an overview of the number of surgeries undertaken by the 7 three consultant neurosurgeons who we've identified -- 8 or you've identified before. In this section, I think 9 you're looking at a dataset that runs from 2005 to 2015, 10 is that right? 11 A. That looks to be correct, yes. 12 Q. Although as we know, from the long list we went to, we 13 actually have access to information about Mr Eljamel's 14 surgeries that pre-date that dataset, in fact, going 15 back to 2003? 16 A. That's correct and that's obviously included in 24.1.1, 17 yes. 18 Q. Indeed but as far as this -- and for comparative 19 purposes if you like, as far as this is concerned, in 20 the eight years that this is covered, Mr Eljamel 21 undertook 422 surgeries but in the wider dataset, he 22 undertook 483, according to the records that you have 23 available to you? 24 A. That's correct. 25 Q. And as far as Dr O'Riordan is concerned, over the Page 149	1 a break. 2 THE CHAIR: Yes. Mr James, we'll take our 15-minute break 3 now and resume again at just on 3.20. If you don't mind 4 not discussing your evidence over the break, that keeps 5 matters regular. Thank you. 6 A. Of course. Thank you. 7 (3.06 pm) 8 (A short break) 9 (3.20 pm) 10 THE CHAIR: Thank you. Right, thank you, Mr James. Ready 11 to resume, Mr Dawson. 12 MR DAWSON: Thank you, sir. Mr James, one aspect of the 13 discussion that we had before the break related to the 14 time commitments which might be given by a consultant 15 surgeon offering private services within a hospital like 16 Fernbrae in comparison -- or in conjunction with their 17 NHS responsibilities. Do I take it from what you said 18 about that, that the responsibility of a consultant lies 19 primarily to their NHS employer in that regard to 20 provide the services that they are contracted to provide 21 there and that any private services they are providing 22 elsewhere requires to be arranged around that primary 23 commitment? 24 A. That has always been my understanding as a consultant, 25 that you have a contract with your employer which must Page 151
1 six-year period in which he appears within these 2 records, he undertook 20 surgeries, is that right? 3 A. That's correct. 4 Q. And in the period over one year between 2014 and 2015 5 when Mr Demetriades offered services, he conducted 6 247 surgeries, is that right? 7 A. That's correct. 8 Q. Does it look possibly like Mr Demetriades took the 9 service over from Dr O'Riordan and Mr Eljamel? 10 A. Again, I have no direct knowledge in which I can answer 11 that but that, I believe, would not be an unreasonable 12 assumption. 13 Q. Because you mentioned earlier one of the factors that 14 would go into the decision-making around what services 15 would be provided would be succession planning, I think. 16 So you were trying to offer a service but not one that 17 would effectively come to an end when a single person 18 came to an end, but a service that one would wish to 19 continue offering to local people for a longer period? 20 A. Yes. 21 Q. So, as I think you accepted, it looks like 22 Mr Demetriades has taken over from the other two, both 23 of whom ceased providing the service in 2013? 24 A. That's correct. 25 MR DAWSON: If that's a convenient moment, sir, to take Page 150	1 be fulfilled. In a different way, you don't have that 2 same contract with us as an independent provider. 3 Q. I see. And so is it the case that the practising 4 privileges system really allows a consultant to offer as 5 much or as little by way of a service as the consultant 6 wishes? 7 A. Correct. 8 Q. I suppose, ultimately, professionally it -- or in terms 9 of the way that the service is being offered, it might 10 mean that when the practising privileges are reviewed 11 every two years, there might have to be a conversation 12 had if someone, for example, wasn't offering any service 13 and therefore the commercial requirement for the service 14 to be offered might be jeopardised by that? 15 A. That would be one of the discussions had at that review, 16 yes. 17 Q. But I suppose within that context if, as we saw, for 18 example Dr O'Riordan offered very few surgeries, only 19 20 over a six-year period, I suppose it would be the job 20 of those running the hospital to work out whether they 21 could engage other consultants to deal with the demand, 22 for example? 23 A. Yes. 24 Q. And as I understand it, the practising privileges system 25 allows a consultant to say to the private hospital: Page 152

1 I'm able to offer this amount of surgeries, but I have 2 obligations elsewhere which are my primary obligations 3 so I can't offer any more; is that right? 4 A. That is correct. 5 Q. Thank you very much. Can I have a look, please, at 6 paragraph 18 of the statement. Paragraph 18.1, please. 7 Could you just go a little bit further up, please just 8 so we can see (a). You are asked there questions about 9 the monitoring of the number and type of -- and reasons 10 for patients being referred for private treatment from 11 Mr Eljamel's NHS practice. And you say you have: 12 "... not been able to establish the answer to 13 question 18(a) [above] based on the searches CHG have 14 conducted of legacy BMI Fernbrae information or data. 15 I am not aware of anyone who would be able to provide 16 information on this. I am aware that in 2003, the 17 Department of Health published a Code of Conduct for 18 Private Practice with which consultants were expected to 19 comply ... I am not aware of a dedicated system through 20 which consultant adherence to this was monitored and 21 I suspect one is unlikely to have existed." 22 So you mention there that you don't have any direct 23 information of the system whereby there might have been 24 monitoring of the type and reasons and numbers of 25 patients being referred for private treatment from Page 153	1 two separate cohorts of patients. The private medically 2 insured and self-funded patients were referred directly 3 or self-referred into the independent sector for speed 4 of access rather than patients going through an NHS 5 route and then changing after a consultation. It's not 6 to say that that didn't happen on the odd occasion, but 7 it wasn't the norm, in my experience. 8 Q. So just to be clear, the second category you're talking 9 about they are the types of patients who would be being 10 treated in an NHS practice and for example would be 11 listed for a surgery and the patient might, for example, 12 want it to happen more quickly and the consultant may, 13 quite legitimately, say: well, I actually have a private 14 practice where I could offer you that much more quickly 15 because I have already assessed that that would be the 16 appropriate surgery and you want to have it. What are 17 you saying about it? Are you saying that that's a small 18 category of patients generally, or not? 19 A. So I accept that that can happen because of the length 20 of NHS waiting lists at times. What I am saying is, in 21 my experience, that is a smaller subset of the patients 22 who present to a private hospital for treatment. 23 Q. Understood. 24 THE CHAIR: Mr Dawson, just to be clear, that sort of 25 patient is what you described in a previous question as Page 155
1 Mr Eljamel's private practice, but you do refer there to 2 a Department of Health code of conduct for private 3 practice from 2013; is that right? 4 A. That is correct. 5 Q. And you have a produced a copy of that, helpfully, to 6 us. Was that applicable in Scotland, do you know? 7 A. That -- I can't confidently answer that. I had always 8 assumed that that was applicable to all consultants 9 practising privileges within the UK and from memory, 10 that particular code of conduct came in at the time that 11 the consultant contract changes occurred. 12 Q. Right. And that happens to be exactly the time when 13 Mr Eljamel started offering his service, it would 14 appear, at Fernbrae, is that right? 15 A. Yes, roughly the same time, yes. 16 Q. On that specific subject that the question was about, as 17 far as the sort of category of patients who could be 18 referred into private care, you mentioned when we 19 discussed before the break, the possibility of having 20 clinics with individuals who may be offered care. Was 21 it an additional group of people who could end up having 22 surgery in a private hospital, could that comprise 23 patients who are patients of the consultant themselves 24 in their NHS practice? 25 A. In my experience and in my specialty they tended to be Page 154	1 the "hybrid" that you were asking the witness about? 2 MR DAWSON: Yes, the type of patient that we describe as 3 a hybrid is one who receives treatment in both the NHS 4 and private care for whatever reason. Yes, sir. 5 THE CHAIR: Yes. 6 MR DAWSON: It's important though -- and I think this is 7 what you're trying to get at in your answer to that 8 question -- that that practice, even if it relates to 9 a relatively small subset of patients, is carefully 10 monitored because there is a potential -- and I think 11 you mention in your statement the Ian Paterson Inquiry 12 and criminal prosecution -- that such a system could be 13 open to abuse if not monitored? 14 A. Yes, it is quite complex to monitor because of the 15 availability of documents from one sector to another. 16 Q. Could you expand on that? 17 A. The private hospital will not always have access to NHS 18 documentation at the point of transfer. 19 Q. So in those circumstances, is there a considerable 20 reliance being placed on -- a word we've heard before -- 21 the probity of the consultant that the referral is 22 necessary, above board and properly consented to? 23 A. I think that's fair. 24 Q. Okay, thank you. Could I ask you, please, to go to 25 paragraph 6.6 of the statement. Thank you very much. Page 156

1 In is a section, Mr James, in which you have provided 2 with us a very detailed breakdown of the various 3 different electronic and other physical searches that 4 have been undertaken for documents by your organisation 5 and the multiplicity of different electronic systems, in 6 particular, which you've gone through and are ones that 7 have been used by the organisation over the years. 8 I particularly wanted to ask you about this section, 9 where you say: 10 "CHG has not been able to access the following 11 legacy system which may hold/have held data relevant to 12 Mr Eljamel's practise ..." 13 And this was the SAFECode system and you tell us 14 there that the type of information or data that it had 15 was: 16 "Incident and complaints data (dates during which 17 this system were in use at BMI are unknown)." 18 You go on to say: 19 "I do not know and have not been able to ascertain 20 which company owned and operated SAFECode or whether it 21 is still operational. If that company is still 22 operational, it is possible that it could access the 23 SAFECode system and, potentially, historic BMI incident 24 and complaint data. I believe that the reason that CHG 25 does not have access to this system is because it was Page 157	1 as you understand it, where incident and complaints data 2 would have been held? 3 A. That is our understanding of SAFECode, yes. 4 Q. And there was another system in use at a certain point 5 called Sentinel which served as similar purpose, is that 6 right? 7 A. That's correct. 8 Q. And I think, although there's a degree of deduction 9 here, you think that perhaps SAFECode was replaced by 10 BMI with Sentinel? 11 A. That's our belief. 12 Q. Because you have been able -- we'll get on to this in 13 a minute -- you have been able to make available to us 14 some information about complaints and discussions about 15 complaints between the private system and the NHS 16 system. Do those come from Sentinel then? 17 A. That is -- my understanding is that is a system that we 18 could access, yes. 19 Q. And it remains at least theoretically possible within 20 the limits of your understanding of how these various 21 different systems are run and operated, that there may 22 be a company that could still unlock that system, if you 23 like, but that may be to a degree speculation to try to 24 be helpful on your part? 25 A. There may be a way of accessing that if we could trace Page 159
1 decommissioned for use in the business a significant 2 period of time before CHG acquired BMI in January 2020. 3 I do not know the dates that it was used within BMI. It 4 is possible that SAFECode was the incident reporting 5 system that was used at BMI immediately before the 6 company replaced it with a new system (Sentinel). 7 I have not been able to ascertain if that is the case or 8 when Sentinel was introduced, but I am aware Sentinel 9 remained in use until 2016. As identified at 10 paragraph 6.4 above, BMI replaced Sentinel with another 11 system (Riskman) in December 2016. From November 2023, 12 CHG replaced Riskman with RADAR." 13 These are various computer systems. So although 14 you, earlier in the statement, detail a number of 15 systems which were used by BMI and Circle still has 16 access to, this was one that Circle does not have access 17 to; is that right? 18 A. That is correct. 19 Q. And I think your deduction is this is not a system that 20 was available to Circle and somehow closed down when it 21 took over BMI, but it was one that wasn't handed over, 22 if you like, when Circle took over the rights and 23 liabilities of BMI; is that correct? 24 A. That is correct. That is our understanding. 25 Q. Thank you. And this was a system, as I understand it -- Page 158	1 the company who now manage that software. 2 Q. Right, and so when we're talking about a company that 3 could access that, we're talking about some sort of 4 technological company that would be able to work out how 5 to open the door to the information; is that right? 6 A. That's right. 7 Q. So rather than some other body that's taken over some 8 aspect of BMI's operation or something like that? 9 A. That's correct. 10 Q. Okay, thank you. Could we go, please, to 11 paragraph 10.6.1. We asked you some questions about 12 internal and external information sharing systems which, 13 according to the information you have available to you, 14 were in place at the time. And you told us that: 15 "The terms and conditions under the BMI 2002 16 practising privileges policy ... included a requirement 17 on consultants to advise the Executive Director of any 18 matters which affect their ability to practise, and of 19 any occurrence or outcome relating to their practise 20 which might reasonably be expected to have the potential 21 of bringing into disrepute their professional standing. 22 This would include, but not be limited to, the 23 following: 24 "The commencement of disciplinary proceedings 25 (whether clinically based or otherwise) at any other Page 160

1 Hospital or unit at which the consultant practised; 2 "Any suspension of or voluntary undertaking by the 3 consultant to limit the scope of, their practising 4 privileges or clinical practice at any other Hospital; 5 or ... 6 "Any investigation to their clinical outcomes or 7 clinical practises. 8 "The BMI practising privileges letter also confirms 9 that, by accepting the terms and conditions, the 10 consultant agrees to the Hospital approaching any other 11 hospital or unit at which the consultant practices at 12 and request clinical practice data (on an anonymised 13 basis) to enable it to form a view as to any clinical 14 incident or other issue related to the consultant's 15 clinical practice ... 16 "CHG's searches have not identified the existence of 17 a formal process during the relevant period for the 18 sharing of information between NHS Tayside and 19 BMI Fernbrae. It should however be noted that the 20 Medical Profession (Responsible Officer) 21 Regulations 2010 did not come into force until 22 [1 January 2011] and therefore the legal framework that 23 now exists for ensuring timely communication of concerns 24 about consultants between organisations did not exist 25 until towards the end of the relevant period. Page 161	1 hospital disciplinary or a GMC disciplinary or whatever. 2 Q. Understood. And you also referred -- and have helpfully 3 produced copies of the BMI "being open" policy, which 4 came in, in March 2010. How did that, broadly speaking, 5 supplement or alter the regime that we've just 6 discussed? 7 A. Again, I had no experience of this at Fernbrae but 8 clearly, the BMI "being open" policy is a way of 9 encouraging staff and hospital employees to raise 10 concerns about clinical practice if they feel that they 11 have issues that they wish to raise. That then, 12 I think, complements the other methods that were already 13 in place before that time. 14 Q. The other methods we discussed as existing in this 15 passage. Those methods relate to effectively 16 self-reporting by a consultant about things that were 17 going on in their practice elsewhere; is that correct? 18 A. That's correct, but also as we discussed the first 19 session, the review around complications that should 20 have been undertaken by the medical advisory committee 21 on regular intervals. 22 Q. Would it not, however, still be -- would the medical 23 advisory committee not still rely on the consultant 24 reporting adverse incidents to them? 25 A. The medical advisory committee is dependent on that but Page 163
1 "Our searches have located a copy of the BMI Being 2 Open policy that was first introduced in March 2010. 3 A copy of this and the associated appendices is 4 exhibited ... It appears this policy was reviewed in 5 2014. I have exhibited a copy of the reviewed version 6 and associated appendices ..." 7 So, based on the searches that you've been able to 8 undertake within the limitations that we've discussed, 9 it appears, in effect, that it is a condition of the 10 practising privileges being granted and renewed for 11 a consultant that consultant inform the private company 12 offering the services of the kinds of significant events 13 in their other practice, if you like, as and when those 14 occur, is that right? 15 A. That is correct. If those events are significant and 16 particularly if there is any investigation into 17 a clinician's practice, our practising privileges policy 18 clearly states that the consultant should make us, as 19 the independent provider, aware of that investigation 20 and those concerns. 21 Q. That's why the passage I just read out talks about the 22 need to inform the executive director of the 23 commencement of disciplinary proceedings, not 24 necessarily the conclusion of such a process? 25 A. That's correct and that is whether that's an internal Page 162	1 also should be reviewing complaints data, return to 2 theatre data, readmission data. All of the measurable 3 data that the hospital can gather forms part of that 4 review process. 5 Q. If something went wrong in surgery in a private hospital 6 would it be theoretically possible that the patient 7 would be transferred back to an NHS hospital for care? 8 A. Very possible. In which case, as you pointed out, that 9 often relies on the individual surgeon alerting the 10 private hospital to the fact that that has occurred. 11 Q. Because, I think you said earlier when you were 12 describing the ambit of the types of surgeries that 13 would be included within practising privileges and 14 offered, that -- you described Mr Eljamel's surgery as 15 broadly, I think, low to moderate complexity as being 16 the sorts of ones that one could responsibly offer in 17 a private hospital; was that broadly correct? 18 A. That's broadly correct. 19 Q. And it may be, of course, that if something did go wrong 20 that some other type of medical service which the 21 private hospital could not offer might be required, such 22 as I think you mentioned, high dependency? 23 A. Yes, I think that dealing with surgical complications 24 is -- whether that's in spinal surgery or other surgical 25 fields, is often more complex than dealing with the Page 164

1 original pathology because when something goes wrong -- 2 that could be infection, that could be bleeding, there 3 could be causes that mean you need to be in a higher -- 4 a hospital that have higher acuity or more highly 5 responsive services than an independent provider 6 hospital. 7 Q. I asked you before you came to give your evidence, 8 shortly before when we met, whether you're aware of the 9 local geography in the area and I think you told me you 10 were not? 11 A. Correct. 12 Q. But is it common for private hospitals to be located 13 fairly near NHS hospitals, for those sorts of 14 considerations? 15 A. It is variable, but it is -- it is not uncommon for 16 private hospitals to be within the proximity of an NHS 17 hospital. Some private hospitals are physically 18 connected with a linked corridor, so form part of the 19 fabric. Others are slightly more remote but often they 20 do co-exist in proximity so that there is safe provision 21 of services across both domains. 22 Q. And if -- you mentioned, I think a moment ago, I was 23 hypothesising a situation in which care did require to 24 be transferred from a private to an NHS hospital and 25 I think you mentioned that that would be a situation in Page 165	1 the consultant has agreed to; is that right? 2 A. That is right. That's a right that we reserve that if 3 there are concerns about a particular doctor, we can 4 gather information from other providers and other 5 hospitals where that doctor works. 6 Q. But, again presumably, that wouldn't happen routinely, 7 it would only be in circumstances where the private 8 hospital had reason to do that? 9 A. That is correct. The routine aspect is obviously that 10 the doctor does undergo an annual full practice 11 appraisal, where that doctor goes through a full 12 practice review and that should include the private 13 practice within that doctor's practice and that 14 appraisal process is supervised by the designated body 15 and is the responsibility of the responsible officer of 16 the individual. You will note from the documents that 17 we have submitted that all independent providers request 18 copies of their annual appraisal for its own 19 documentation and assurance. So that level of 20 information exchange I would have expected to have 21 happened but beyond that, if there were no concerns 22 raised, then no further detailed analysis would have 23 been undertaken. 24 Q. So an annual appraisal would take place which would be 25 the responsibility of the responsible officer, is that Page 167
1 which the private hospital would rely on, I think, the 2 candour of the doctor in informing that that happen. 3 Would that be correct? 4 A. That would be correct. If that admission to the local 5 NHS hospital occurred after discharge, then the private 6 hospital is not routinely informed of that admission. 7 We rely on that information being gathered and at this 8 time, that would have come from the treating surgeon. 9 Clearly if a patient deteriorates whilst in 10 hospital -- one of our hospitals and needs transfer out, 11 as a protective measure, we are aware of that transfer 12 so -- but the majority we will not be aware of. 13 Q. Understood, because you might have a record of 14 an ambulance having to take the patient or something 15 like that? 16 A. Yes. 17 Q. And there would be staff who are employed within the 18 hospital, like the scrub nurse, for example, who would 19 be aware of it having happened? 20 A. That's right. 21 Q. You indicate, in the passages that I have just read out, 22 I think, that the practising privileges letter permits 23 a private hospital to approach any other hospital or 24 unit to request clinical data. So effectively, that's 25 something that, as part of the practising privileges, Page 166	1 right? 2 A. That is correct. 3 Q. And is it a feature of the responsible officer system -- 4 I think you've told us -- that that annual appraisal 5 came about? 6 A. Yes, and that annual appraisal now underpins what has 7 become revalidation within the medical profession with 8 the General Medical Council. 9 Q. Indeed, I think you've helpfully told us that that came 10 in, in 2011, is that right? 11 A. From memory, the revalidation is actually 2012. 12 Q. Yes. 13 A. The responsible officer guidelines or recommendations 14 came in on 1 January 2011. 15 Q. So effectively over that kind of period, 2011 to '12, 16 this system was being evolved, if you like; is that 17 right? 18 A. That is right. 19 Q. And I think you told us that in circumstances where -- 20 like Mr Eljamel, where you're conducting most of your 21 surgeries within the NHS hospital, your responsible 22 officer would be within that side of the operation, if 23 you like; is that right? 24 A. That's correct. 25 Q. And because of the fact that if you had have a private Page 168

1 practice, the responsible officer there is not 2 responsible for you in those circumstances, I think you 3 also told us that it would be expected that the 4 appraisal would contain an analysis of issues that had 5 arisen in your private practice as well? 6 A. That should happen, yes. 7 Q. And would in those circumstances the NHS hospital have 8 access to the records that exist within the private 9 hospital or would they be relying on the consultant to 10 report that? 11 A. They would be relying on the consultant to report that 12 as part of his or her full practice appraisal. 13 Q. Okay. So, in circumstances -- I think you describe in 14 your statement that you would expect there -- when this 15 system was up and running from 2012, there to be some 16 degree of dialogue, if you like, between the responsible 17 officers and the two organisations about doctors and 18 their revalidation requirements, is that right? 19 A. Certainly, from the introduction of the responsible 20 officer regulations, we would expect -- or I would 21 expect -- and certainly now, as a responsible officer 22 myself, any concerns or issues we have with a practising 23 doctor, we would expect those concerns to be made known 24 to the responsible officers of every organisation where 25 that doctor works. Page 169	1 Q. I suppose really -- the essence of this is really what 2 would, in reality, trigger those concerns. Because 3 would you be of the view that the NHS should have been 4 providing -- expressing concerns in 2011 when three 5 patient complaints, including a complaint of 6 a wrong-site surgery was made about Mr Eljamel? 7 A. I think that is difficult for me to answer without 8 access to the detailed documentation from NHS Tayside. 9 Understanding the degree of concern, I guess the 10 background to those concerns is important, as to whether 11 that becomes at a level where a responsible officer 12 feels that that requires onward dissemination. I think 13 it's very difficult for me to give an opinion on that 14 without sight of the relevant information. 15 Q. In many ways, the difficulty that you face, Mr James, is 16 precisely the point, is it not, because someone who is 17 in charge of that system within the private hospital 18 needs access to the information in order to be able to 19 ascertain whether it's something they feel they need to 20 do something about? 21 A. Yes, and that is the whole -- what underpins the 22 information-sharing principle. 23 Q. And you don't have access to that information because in 24 the bundle that you have, there is no evidence of any of 25 that from 2011 being communicated, was there? Page 171
1 That is clearly important to alert all hospital 2 groups, whether NHS or private, to the concerns that 3 have been raised and allows discussion and collaboration 4 between organisations to actually discuss strategies to 5 investigate and deal with those concerns. 6 Q. So I think you tell us in the statement that you -- 7 based on the limitations of the documentation you have, 8 you didn't find any evidence of information about 9 Mr Eljamel being shared in the period we are talking 10 about, until effectively after he had completed his work 11 at Fernbrae, isn't that right? 12 A. That is correct. 13 Q. Yes, but what you're trying to help us with now is that 14 you would expect such a system to exist, and that it may 15 have existed but it might have been more of a "local 16 arrangement", I think is the expression you use? 17 A. I think like a lot of governance processes that have 18 developed in healthcare, there is a process of 19 maturation and certainly now, it is robust. I have 20 obviously no knowledge or experience of how far robust 21 the system was at its launch, in infancy. 22 Q. And you mentioned that such systems would be designed, 23 I think, to enable the communication of concerns about 24 a consultant; is that correct? 25 A. That's correct. Page 170	1 A. No, we couldn't find any evidence. 2 Q. So in the same way as you can't offer an opinion and 3 you've explained why, neither could those in your role 4 within Fernbrae at the time because it appears they 5 didn't have that information either? 6 A. That's our understanding, yes. 7 Q. And indeed, in -- if four further complaints including 8 a complaints about wrong-site surgery were made about 9 Mr Eljamel in 2012, would that, further, be material 10 which the authorities within Fernbrae would wish to have 11 access to, to work out whether they wished to do 12 something about it? 13 A. Again, I don't wish to comment on other organisations 14 but from our perspective, sight of that information 15 would be very useful in making determinations about his 16 continued practice, yes. 17 Q. And presumably -- I almost used a Latin expression 18 there, but I promised that I wouldn't -- if eight 19 further complaints were made in 2013 of a similar 20 nature, would that add to the picture that the private 21 hospital would wish to know about, in order to try to 22 make those important decisions? 23 A. Yes. 24 Q. If it were the case that these complaints had reached 25 a point, in 2013, that NHS Tayside thought it Page 172

1 appropriate to commission a Royal College of Surgeons 2 individual invited review into Mr Eljamel's practice, 3 again, would that be something that should be 4 communicated by the board to Fernbrae? 5 A. We would expect, with that level of concern, for some 6 contact to be made. And also, as per the practising 7 privileges policy, now there is a formal investigation 8 into the individual doctor, we would expect that also to 9 be communicated to the hospital director by the relevant 10 consultant. 11 Q. Indeed. So we're into a new territory now, where the 12 sort of broad categories of investigations that we 13 listed from the practising privileges document now mean 14 Mr Eljamel should have been telling Fernbrae that as 15 well, irrespective of whether NHS Tayside had those 16 obligations before that point? 17 A. That is obligations under the practising privileges 18 policy which was in place at the time. 19 Q. Would that also apply to Mr Eljamel being placed under 20 clinical supervision in 2013? 21 A. That would apply. It would be a similar circumstance. 22 Q. Would it apply in circumstances where he was suspended 23 from practice? I think that's clear from the document 24 that it does. 25 A. That is absolutely clear that that should be Page 173	1 and that they had found no additional cases which were 2 of concern. A number of these were patients who had had 3 their procedures performed in BMI and were now attending 4 the NHS pain clinic. 5 "Based on this information I do not believe we need 6 to do a retrospective review of all his BMI patients -- 7 a number of whom would have been reviewed by the Trust 8 in any case. 9 "Kind regards, Mark." 10 So in this communication what's being discussed is 11 Dr Ferreira is passing on, to one of his colleagues 12 within Fernbrae, information about a conversation he had 13 just had with Dr Russell, who we know was the medical 14 director at Ninewells; is that correct? 15 A. That is my understanding, yes. 16 Q. And he explains to his colleague that, by this point 17 within BMI, there had been three patient complaints made 18 against Mr Eljamel; is that correct? 19 A. That's correct. 20 Q. And that the three patient complaints regarded potential 21 wrong level or incorrect site surgery; is that correct? 22 A. That's correct. 23 Q. And by this point, Dr Russell had informed him that 24 there had been a retrospective review of 25 Professor Eljamel's patients and that they had found no Page 175
1 communicated. 2 Q. Could I have a look, please, at CHG-00287. Just zoom in 3 on that, please, thank you. This appears to be an email 4 from the 1 August 2014 from a Mark Ferreira to a Louise 5 Buchan; is that right? 6 A. That's correct. 7 Q. And the email -- who are those individuals, as far as 8 you're aware? 9 A. Mark Ferreira was a medical director of BMI Healthcare. 10 Louise Buchan, I understand, was the hospital director 11 at Fernbrae Hospital. 12 Q. So this is correspondence from the private side, if you 13 like, to the Ninewells Hospital; is that right? 14 A. No, this is Fernbrae. This is internal communication. 15 Q. Thank you. So it says: 16 "Dear Louise. 17 "I discussed [Professor] Eljamel with the Trust 18 Medical Direction, Dr Russell by phone a short while 19 ago. I informed Dr Russell that we now had three 20 patient complaints regarding potential wrong 21 level/incorrect site surgery and also that we would 22 inform the GMC of the most recent (new) complaint which 23 they may not yet be aware of. 24 "Dr Russell confirmed that Trust had completed 25 a retrospective review of [Professor] Eljamel's patients Page 174	1 additional cases which were of concern. Does that 2 appear to be the position? 3 A. That's -- that's my interpretation of the letter, yes. 4 Q. And as a result of that Dr Ferreira, it would appear, 5 decides that because that information has been imparted 6 to him, that he did not believe that they needed -- this 7 is BMI -- needed to do a retrospective review of 8 Mr Eljamel's patients whom he had treated in the private 9 hospital; is that correct? 10 A. That is correct, yeah. 11 Q. Does there appear to be there an assumption, on 12 Dr Ferreira's part, that the NHS review will have 13 covered any private patients who fall within the 14 category of "concerning"? 15 A. I can't really answer that with confidence. Clearly, 16 the letter does state that a number of the patients 17 reviewed by the NHS had had their procedures performed 18 in BMI, as they were now attending the NHS pain clinic. 19 So you could infer from that that Dr Ferreira was 20 reassured that the patients were already under review, 21 but other than that, I can't comment with confidence. 22 Q. I suppose, at the end of the day, it will be a matter 23 for the Chair at that determine whether that was 24 a reasonable assumption to make, but that was the 25 position as at that point. If we could look, please, at Page 176

1 some other correspondence. In fact, let's look at the 2 statement. At paragraph 42, you've helpfully provided 3 a summary for us. So you were asked here about 4 complaints and concerns being raised on the basis of the 5 information you had from BMI. It says, at 42.1: 6 "The records located in CHG's searches indicate that 7 the first complaint regarding Mr Eljamel's practise at 8 BMI was notified to Fernbrae in April 2014, after 9 Mr Eljamel's practising privileges had been withdrawn. 10 The [complaint] was [by a certain individual]. It 11 appears that the complainant in that case made the 12 complaint to the GMC in February 2014, rather than 13 directly to BMI. The GMC subsequently informed BMI of 14 the complaint and requested BMI to provide any 15 information that may be relevant to their investigation 16 into the concerns. BMI's response confirmed that there 17 had been no other complaints, incidents or concerns 18 raised about Mr Eljamel during the period he had 19 [practising privileges] at Fernbrae. The GMC 20 contacted ..." 21 So that was the position with one complaint 22 in April 2014, it would appear, which had come to BMI 23 via the GMC; is that right? 24 A. That is our understanding, yes. 25 Q. So the reply would tend to indicate that at that stage, Page 177	1 had raised concerns regarding Mr Eljamel." 2 Is that your understanding of the complaints 3 documentation as it existed and is available to you? 4 A. That's our understanding. 5 Q. It goes on to say: 6 "The actions taken by BMI in response to the 7 complaints are detailed through the exhibited 8 correspondence as [I] outlined above. In broad terms, 9 the concerns were reviewed and responded to. In 10 response to [a certain] complaint ... an independent 11 review of the patient's care was obtained. That review 12 was completed in November 2014 by 13 Professor Peter Hutton, (part of FH Partnership), who it 14 appears (based on a GMC search) was a consultant 15 anaesthetist with the GMC number: [et cetera]. The 16 report also indicates that input from a specialty 17 advisor was also sought, but the name and details of 18 that individual are not cited in the document." 19 If we could, please, look at that document briefly. 20 The document number is CHG-00286. And this relates -- 21 page 47, please. Just to be clear, you provided this 22 document to us in a bundle of other documents which 23 contains a number of letters from solicitors to BMI, 24 I think relating to concerns and potential claims by 25 clients of theirs, relating to treatment which was Page 179
1 there was this single complaint and that BMI was not 2 aware of any other complaints at that point? 3 A. That is correct. 4 Q. It goes on to say: 5 "The GMC contacted BMI in August 2014 confirming 6 that their investigation into the patient's complaint 7 had closed without further action. Copies of the 8 correspondence relating to this matter are exhibited." 9 Then, you say: 10 "Please note that [a certain document] sent to us 11 via the GMC with redactions already applied." 12 You're doing that to indicate that you haven't 13 applied the redactions, but the GMC applied them? 14 A. Yes, correct. 15 Q. "Our searches indicate that we do not possess 16 a non-redacted copy BMI Fernbrae received complaints 17 from other patients of Mr Eljamel in June 2014 18 (1 complaint ...), July 2014 (1 complaint ...), 19 August 2014 (1 complaint ...), [and] September 2018 20 (1 complaint ...), November 2018 (2 complaints ...) and 21 another raised [in addition to that]. BMI Fernbrae was 22 also notified of a potential claim by a patient ... 23 in March 2016 ..." 24 So, you've summarised, helpfully, by saying: 25 "Between 2014 and 2018, a total of 8 BMI patients Page 178	1 provided by Mr Eljamel at Fernbrae Hospital; is that 2 correct? 3 A. That is correct. 4 Q. And amongst those, you provided this report. Could you 5 go down to the bottom of this page, please. This report 6 relates to treatment that was received by a patient in 7 2010, is that right? 8 A. That is correct, yes. 9 Q. Yes, and it says the conclusion that's reached: 10 "The decision to operate on a lumbar disc is usually 11 made on a combination of clinical and radiological 12 findings. In current practice, surgery is indicated 13 only where there is an evident physical lesion 14 demonstrated on a scan that could explain the clinical 15 findings. 16 "The patient ... had an MRI scan performed on 17 31st August 2010. [Professor Sam Eljamel]'s 18 interpretation of this scan in his letter of 19 7th September 2010 ... is at very significant variance 20 with the radiologist ... the neurosurgeon to whom she 21 was referred for a second opinion ... and FHP's 22 independent specialty adviser ..." 23 So the interpretation of the scan which was 24 undertaken by Professor Eljamel, according to this 25 report, was at very significant variance with, first of Page 180

1 all, the radiologist who conducted the scan; is that 2 correct? 3 A. That's correct. 4 Q. The neurosurgeon to whom the patient was referred for 5 a second opinion; is that correct? 6 A. That is what the report states, yes. 7 Q. Yes, and finally, the independent specialty adviser who 8 was brought in to help with the production of this 9 independent report, it would appear? 10 A. Correct. 11 Q. And it says: 12 "The opinions of the radiologist, the neurosurgeon 13 who gave the second opinion, and the independent 14 adviser, indicate that there was no demonstration of 15 nerve compression amenable to surgical treatment at the 16 L5-S1 level. 17 "There is no further evidence that any additional 18 scanning was carried out on [the patient] after 19 31st August 2010 and before 7th September 2010 when the 20 letter was sent. 21 "There is also no evidence that there was any 22 further scanning undertaken, or any sudden deterioration 23 in symptoms between the date of the letter 24 (7th September 2010) and the surgery 25 (15th September 2010). Page 181	1 A. That's correct. 2 Q. Okay, going back to the statement, please, at 3 paragraph 42.2. Down to the bottom, please, eight lines 4 from the bottom, where you see, about three quarters of 5 the way across, the name "Louise Buchan", do you see 6 that? 7 A. Yes. 8 Q. "Louise Buchan, Executive Director of BMI Fernbrae ..." 9 This is in relation to this particular case: 10 "... also made the decision to refer the concerns 11 arising from [this] case to the GMC, and provided the 12 GMC ... with a copy of [the] report. That notification 13 was sent on 11 November 2014 ... [And] a decision to 14 refer the case to the GMC was also made in relation 15 to ..." 16 Another case; is that correct? 17 A. That's correct. 18 Q. And: 19 "That step was taken by/on the advice of [the] Group 20 Medical Director, Mark Ferreira [who we've seen], in or 21 around August 2014 ... The reason for these decisions 22 is not specified but I presume this was due to those 23 involved having considered that the nature of the 24 concerns were sufficiently serious to warrant this 25 action. It also appears that BMI's Medical Director Page 183
1 "It is difficult to understand the intra-operative 2 findings based on the pre-operative MRI scan." 3 And then, in relation to key points, it says: 4 "From the evidence available at the time of 5 undertaking this review, there is a prima facie case 6 that Professor Sam Eljamel seriously misinterpreted the 7 MRI scan performed on 31st August 2010 and subsequently 8 undertook an unnecessary operation." (As read) 9 And in conclusion, relating to clinical governance 10 and fitness to practice issues, it says: 11 "The content of this report brings into question 12 whether or not Professor Sam Eljamel has the clinical 13 competence to work as an unsupervised consultant in this 14 area of practice." (As read) 15 Is that what the report says? 16 A. That's what the report says, yes. 17 Q. And the report is dated November 2014, isn't it? 18 A. It is. 19 Q. And that's because it was at that time that there was 20 an instruction for this independent review to be carried 21 out, at around that time? 22 A. That's correct. 23 Q. And despite that, it relates to events which have given 24 rise to those conclusions in a much earlier period, in 25 2010, is that right? Page 182	1 (Mark Ferreira) had a discussion about the emerging 2 concerns with ... (Dr Russell) on 1 August 2014 ..." 3 And that's the correspondence that we've already 4 looked at which referred to there being three patient 5 complaints by that point; is that correct? 6 A. That's correct. 7 Q. Excuse me just one second. (Pause). 8 Could I ask you, please, to look at CHG-00288. 9 I think when we were looking through the details 10 earlier, Mr James, of the surgeries performed by 11 Mr Eljamel, we understood that he didn't provide any -- 12 he didn't carry out any surgeries after July 2013; is 13 that right? 14 A. Those our understanding, correct. 15 Q. Yes, and I think your assessment of the material 16 available to you is that there wasn't any communication, 17 at that stage, by anyone relating to what was happening 18 in his NHS practice at that time; is that correct? 19 A. Not from -- there was communication, as I understand it, 20 from Eljamel himself. 21 Q. Yes. 22 A. But that is all that we could find. 23 Q. But relating to what was going on in his NHS practice, 24 no? 25 A. No. Page 184

46 (Pages 181 to 184)

1 Q. Could we look, please, at CHG-00288, at page 1. This 2 is -- if we could scroll down a little bit please, we've 3 got an email there from 19 December 2013. This is from 4 Louise Buchan, who we've seen before to, I think, 5 various people within BMI, including Mark Ferreira, who 6 we've seen already; is that correct? 7 A. That's correct. 8 Q. And so this is, again, correspondence from 9 Louise Buchan who is the executive director of Fernbrae, 10 on 19 December 2013; is that right? 11 A. That's correct. 12 Q. And in this, she says to her colleagues: 13 "I've received the attached letter from one of our 14 consultants informing me he has been suspended from his 15 NHS post at Ninewells forthwith." 16 That's Professor Eljamel, isn't it, that she is 17 talking about? 18 A. It is, yes. 19 Q. "I've discussed it with our MAC Chair and apparently he 20 and the neurosurgery department have been under a review 21 at the request of NHS Tayside by the Royal College of 22 Surgeons." 23 Does it appear, from that sentence, that the 24 information that was available was that the review 25 undertaken by the Royal College of Surgeons was into Page 185	1 and therefore needed to stop seeing patients at that 2 time? 3 A. That's my understanding, yes. 4 Q. So this was what you were referring to earlier, when you 5 said there had been some communication around that time, 6 but your understanding from that email is that the 7 communication was from Mr Eljamel himself to Fernbrae? 8 A. That's correct, that's our understanding. 9 Q. And that the communication was that he required to stop 10 offering surgeries at Fernbrae because he was unwell? 11 A. That's correct. 12 Q. And you haven't seen any documentation, as I understand 13 your evidence, that suggests that there was any 14 communication, at around that time, from either 15 NHS Tayside or Mr Eljamel, of issues that were going on 16 with his clinical practice in the NHS at that time? 17 A. Yeah, our document search has not identified any such 18 documents. 19 Q. Okay, thank you. And if I could ask you, in this 20 document, please, to go to page 5. Again, this is 21 a bundle of correspondence which is all around the same 22 period, is that right? 23 A. It is, yes. 24 Q. Which you found in the documentation you have access to? 25 A. Correct. Page 187
1 both him and the neurosurgery department? 2 A. That is what is inferred in the letter, correct. 3 Q. Yes, and it says: 4 "This was in response to a number of NHS patient 5 complaints and there is concern around the incidence of 6 surgery being performed at the incorrect spinal level. 7 [And that] the matter is now being referred to the GMC." 8 As of December 2013. 9 That represents Ms Buchan's understanding, it would 10 appear? 11 A. That's correct. 12 Q. She goes on to say, referring to an earlier period in 13 time: 14 "[Professor] Eljamel had informed the hospital 15 in July that he was unwell and needed to stop seeing 16 patients at Fernbrae, so he has not practiced with us 17 since then. We have no history at Fernbrae of clinical 18 patient complaints involving [Professor] Eljamel, nor is 19 there any concern regarding untoward incidents involving 20 his patients. We will now of course withdraw his 21 privileges at Fernbrae with immediate effect." 22 So, focusing on the first part of that. This seems 23 to be Ms Buchan trying to give some context to this 24 development by saying that Professor Eljamel had 25 contacted Fernbrae in July indicating that he was unwell Page 186	1 Q. This is a letter dated 20 December 2013, is that right? 2 A. Yes, correct. 3 Q. It's a letter from Dr Andrew Russell, the Medical 4 Director of NHS Lothian, to Mr William Paxton of 5 GMC Scotland, is that correct? 6 A. That's correct. 7 Q. It relates to Professor Eljamel, is that right? 8 A. Yes. 9 Q. And it says: 10 "Following up a recent conversation with regard to 11 this doctor within NHS Tayside, who has been suspended 12 within the last two weeks. The suspension follows 13 an external review conducted by the Royal College of 14 Surgeons in England. I have enclosed a copy of the 15 report along with the documentation NHS Tayside 16 submitted to the review team. 17 "You will see they have raised concerns with regard 18 to both probity and ongoing issues with wrong site 19 surgery. 20 "We are in the process of reviewing 21 Professor Eljamel's spinal surgery cases with a view to 22 deciding whether or not there are further wrong level 23 surgeries that have not as yet been identified. There 24 are 150 patients in the cohort that we believe to be at 25 high risk. These are patients with spinal surgery and Page 188

1 who are also attending the local pain service. This 2 initial audit will be completed early in the New Year 3 and we will update on the outcome of that as soon as it 4 is available. 5 "We would be keen not to duplicate any investigatory 6 processes and would value your thoughts as to how you 7 wish to proceed." 8 So this appears to be a letter connected -- which 9 was referred to, I think, in earlier documentation that 10 we've seen, which has been copied, I think, to BMI, its 11 correspondence with Dr Russell telling the GMC in 12 Scotland about the outcome of the investigation by the 13 Royal College? 14 A. Correct. 15 Q. And that's dated 20 December 2013? 16 A. Correct. 17 Q. Thank you. Is there any information available to you 18 within the documentation as to how Dr Russell's figure 19 of 150 patients that he considered to be in a cohort 20 that were at high risk was arrived at? 21 A. I haven't seen any. 22 Q. Would that be information that would be of interest, at 23 that stage, to those responsible for making decisions 24 around these matters within the private hospital on the 25 basis that it would, if further extrapolated, give some Page 189	1 considering current circumstances, I would not be coming 2 back." 3 Is that what it says? 4 A. That's what it says, yes. 5 Q. If we can go over to page 10, please. This is a letter 6 dated 13 August 2015, if we just scroll down, it looks 7 to be -- it's from Mr Tim Millea, an investigation 8 officer within the finance to practise directorate; is 9 that within the GMC? 10 A. Within the General Medical Council, yes. 11 Q. And again, this is another letter which is addressed to 12 Mrs Buchan, I think, relating to Mr Eljamel? 13 A. Correct. 14 Q. It says: 15 "During our investigation into Dr Eljamel he applied 16 for voluntary erasure from the Register. 17 "The case examiners have considered Mr Eljamel's 18 application. They have decided to grant the doctor's 19 application and his name will now be removed from the 20 Medical Register ... Mr Eljamel's licence to practise 21 will be withdrawn and he/she will not be able to 22 practise in the UK. 23 "If Mr Eljamel applies for restoration to the 24 Register, the application will be referred back to the 25 case examiners for consideration. We would take into Page 191
1 sort of indication as to the scale and the possible 2 ramifications of what they were in the course of 3 discovering? 4 A. I think all information relating to concerns about 5 clinical practice are important at this stage. 6 Q. Thank you. Could we go to page 9, please. This is 7 a letter from Professor Eljamel himself dated 8 10 December 2013; is that right? 9 A. Yes, correct. 10 Q. And it's on headed note paper that has his picture 11 there? 12 A. Yes. 13 Q. It says -- this is a letter to Louise Buchan, whom we've 14 seen, again, referred to as the CEO there; is that 15 correct? 16 A. She's the executive director, but yeah. 17 Q. That's right. It says: 18 "Dear Louise. 19 "Further to my previous discussion, I would like to 20 inform you that NHS Tayside has suspended me from 21 practice effective from [December] 10th 2013 at 22 14.45 [hours]. 23 "I am sorry it had gone that far and I will keep you 24 posted if I hear anything else. 25 "I really have enjoyed my time at BMI Fernbrae, but Page 190	1 account any previous evidence about Mr Eljamel's fitness 2 to practise and may open another investigation before 3 any decision is made. 4 "The decision to grant Mr Eljamel's voluntary 5 erasure also marks the conclusion of our enquiries." 6 In what capacity do you understand that that letter 7 would be sent to Ms Buchan given that, by this stage, 8 Mr Eljamel was no longer practising at the hospital? 9 A. It's sort of practice for all consultants to make known 10 where they worked to the General Medical Council. So 11 the General Medical Council would and should have been 12 aware that he worked in the NHS but also at which 13 private hospitals that individual worked. Any update, 14 therefore, about an individual's licence to practise and 15 registration that is decided by the General Medical 16 Council needs to be communicated to all relevant 17 parties, hence this letter being copied to Ms Buchan. 18 Q. And presumably, there would be a process within the GMC 19 that would lead to that endpoint; is that how it works? 20 A. That is how I believe the GMC works. Clearly, that is 21 a matter for the GMC. 22 Q. Yes, of course. Of course. But is it -- I don't know 23 whether in your capacity you've ever -- have you ever 24 dealt with any situations where you get intimation of 25 voluntary erasure? Page 192

1 A. Yes, it's not an uncommon thing to happen, particularly 2 at the end of an individual's career in retirement. 3 Most doctors, at retirement, will apply for voluntary 4 erasure from the register. 5 Q. And is it normal, in those circumstances -- obviously, 6 we see here a letter informing BMI of the fact that that 7 has happened, there has been a decision to grant his 8 application for voluntary erasure -- but would it be 9 normal for there to be correspondence sent during the 10 course of the process leading up to that, after the 11 application for voluntary erasure had been made, to 12 a private hospital? 13 A. If the doctor is still working in the private hospital 14 and a doctor applies for voluntary erasure, then all 15 places -- hospitals where that individual works will be 16 asked to comment if there are any outstanding 17 performance concerns before voluntary erasure is 18 granted. Clearly, in this case, the GMC already had 19 notice of concerns and by the time that the application 20 for voluntary erasure was made, it was clear Eljamel did 21 no longer work within BMI Fernbrae and for BMI. Whether 22 or not the GMC would have reached out, I think is 23 a matter for the GMC but I would not be surprised if 24 they didn't given, the fact that he hadn't had 25 an association with BMI Fernbrae for such a period of Page 193	1 however have been in the NHS rather than in the private 2 hospital, is that correct? 3 A. That is correct. 4 Q. Thank you. Sir, I have no further questions at this 5 stage. I would just like to invite you, Mr James, at 6 this stage if there's anything else you would like to 7 say in addition to the evidence you've already given? 8 A. I would. I think it's important to take the opportunity 9 to acknowledge the impact that has happened to a number 10 of patients, both NHS and private, and I do that 11 personally as a practising surgeon, now retired. As 12 Chief Medical Officer, Circle, and on behalf of Circle 13 Health Group and that I think is what I would like to 14 say and just let everyone know our sympathies and 15 concerns. 16 Q. Thank you. 17 THE CHAIR: Thank you. 18 MR DAWSON: A short break now, sir. 19 THE CHAIR: Yes, we'll take a short break. The purpose of 20 that break is just to ensure that there aren't any 21 further questions that parties wish to raise so we'll no 22 doubt resume again shortly while process is done. 23 A. Thank you very much. 24 (4.20 pm) 25 (A short break) Page 195
1 time. But I may be wrong and that is for the GMC to 2 comment on. 3 THE CHAIR: Just clarify for me, if you will, when the 4 practising privileges were withdrawn in December 2013 if 5 I have that right when the events that the previous 6 correspondence occurred, would that development have 7 been reported by the private hospital director to the 8 GMC? 9 A. The fact that practising privileges were withdrawn would 10 not trigger an automatic GMC communication but it is 11 clear from subsequent documentation that BMI did 12 communicate with the General Medical Council. But 13 withdrawing practising privileges per se does not 14 trigger a routine GMC of itself, yes. 15 MR DAWSON: I think it's the case, just on that subject of 16 whether the private hospital or BMI would be contacted 17 during the course of the process leading up to that end 18 point, the correspondence that you have provided -- that 19 you have found does not contain, as I understand it, any 20 correspondence suggesting that there was an intimation 21 to BMI or that their views on voluntary erasure were 22 sought, is that right? 23 A. That is correct. 24 Q. Thank you. And I think you said earlier Mr Eljamel, 25 while he was in practice, his responsible officer would Page 194	1 (4.31 pm) 2 MR DAWSON: Briefly, sir, yes. Mr James, you gave evidence 3 earlier about there being two potential models which 4 could be used in connection with support service, if 5 I can put it that way, being provided to a consultant 6 surgeon exercising his or her practising privileges in 7 a private hospital, one whereby the surgeon could be 8 supported by staff, potentially a scrub nurse, who would 9 act as first assistant, and in those circumstances that 10 individual would be likely to be employed by the 11 hospital. And you mentioned also a possibility that the 12 first assistant role could be effectively undertaken by 13 a junior doctor or other member of staff who perhaps 14 isn't employed who like the consultant would be coming 15 to the hospital from outside. 16 In that latter case what would -- how would the 17 remuneration and other conditions of that first 18 assistant who is not employed by the hospital work? 19 A. From my experience any individual coming into our 20 hospital from outside would have to provide evidence of 21 relevant registration, indemnity so that they have full 22 medical malpractice cover, and immunisation status so 23 that we know that they can come in and operate safely. 24 The model that historically applied and I used for many 25 years is the remuneration to the assistant is paid by Page 196

1 the operating surgeon. So the relationship is between 2 the surgeon and the operating assistant, if it's from 3 outside rather than with Circle Health Group paying that 4 individual. 5 Q. So effectively that would mean that the assistant 6 brought from outside would by perhaps informal 7 arrangement with the consultant get a cut of the 8 consultant's fee, would that be fair? 9 A. That's a description, yeah. 10 Q. And as far as the assurances that would be required, 11 would there be a formal process that some of the things 12 that you've mentioned there, the requirement to have 13 indemnity, to have immunisation status are the sorts of 14 things that one sees appearing in the sort of standard 15 form practising privileges letter that you've given to 16 us. Would a similar document to that require to be 17 executed, signed by the first assistant arriving from 18 outside or would it simply be the matters that you 19 mentioned? Because there are other matters in the 20 practising privileges document. 21 A. Yes, there are, but because that individual is not 22 undertaking sole practice they are there for a very 23 limited scope which is assisting at surgery. The 24 important matters to check are registration so that they 25 are appropriately -- a member of an appropriate Page 197	1 MR DAWSON: Nothing further today, sir. 2 THE CHAIR: All right. Thank you very much. 10 o'clock 3 tomorrow morning. 4 (4.36 pm) 5 (The hearing adjourned until 10.00 am on Wednesday, 6 16 September 2026) Page 199
1 regulated body that allows them to assist at surgery, 2 medical indemnity and occupational health clearance. 3 The other matters such as a reference and other 4 things because they're not delivering is less important 5 for those individuals. 6 That's certainly my experience of how it worked 7 20 years ago at that time when you brought a junior 8 doctor with you to help assist. 9 MR DAWSON: Okay. Thank you very much. Nothing further, 10 sir. 11 THE CHAIR: Thank you. That is the end of your questions, 12 Mr James. Just before you go, can I just say to you 13 that I am very conscious that in reading your statement 14 it is not just a lengthy document that would have taken 15 a lot of work to put together but encompasses what were 16 clearly searches in a variety no doubt of different 17 places for documentation that were deemed to be relevant 18 to the Terms of Reference. I don't underestimate the 19 amount of work involved in that. So in expressing my 20 thanks and the thanks of the Inquiry to you for giving 21 evidence today, and offering your insights and 22 reflections that you've done, I'm also taking account of 23 the work that went into that exercise as well, it's very 24 much appreciated, and with that you're free to go. 25 A. Thank you, sir. Page 198	1 INDEX 2 PAGE 3 MR ROBBIE PEARSON1 4 (affirmed) 5 Questions by COUNSEL TO THE1 6 INQUIRY 7 MR PETER JAMES (sworn)104 8 Questions by COUNSEL TO THE104 9 INQUIRY Page 200

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