Witness Name: Robbie Pearson
On behalf of Healthcare Improvement Scotland (HIS)
Statement No: HIS-00047

Dated: 16 March 2026

ELJAMEL INQUIRY WRITTEN STATEMENT OF ROBBIE PEARSON

I, Robbie Pearson, will say as follows:

Part A Roles and Responsibilities

1. **Please set out your qualifications. If there is more than one contributor to the statement, please set out the qualifications of each, with a description of which part(s) of the statement each one contributed and why.**

   1.1. Set out in response to question 2 below.

2. **Please explain your professional/ occupational background, in particular focussing on roles and the responsibilities which you held/ hold relevant to or potentially relevant to the neurosurgical department of Ninewells Hospital or Mr Eljamel. If you wish, you may exhibit a CV/ CVs with your statement.**

   2.1. I have held the position of Chief Executive of Healthcare Improvement Scotland (HIS) since 2016. I was previously the organisation's Deputy Chief Executive/Director of Scrutiny and Assurance from March 2012. I was Chair of the NHS Board Chief Executives Group for two years from April 2023 ending in April 2025.

   2.2. I graduated from St Andrews University, with a MA (Hons) Economics and Management joining the NHS general management training scheme in 1992. As part of the training programme, I had spells at Aberdeen Royal Infirmary (November 1992 to August 1993) and at Ninewells Hospital (August to November 1993). The post as a general management trainee at Ninewells Hospital was working in the office of the Trust Chief Executive and did not involve any time in the Neurosurgery

department. I joined Borders Health Board in November 1993 in my first substantive NHS post after leaving the NHS training scheme. I held a number of senior posts in NHS Borders prior to being appointed director of planning and performance in 2003 and becoming an executive member of the NHS Borders Board in 2007. I was seconded to Scottish Government in 2010 and became interim deputy director of healthcare planning. The post was responsible for policy and planning in major clinical priorities such as heart disease and cancer. On 1 March 2012, I was appointed Director of Scrutiny and Assurance in Healthcare Improvement Scotland. This was a new role in the redesigned leadership arrangements with the formation of Healthcare Improvement Scotland. A major initial priority on assuming the role was to review the management of adverse events in NHS Ayrshire and Arran and which was subsequently extended to all NHS boards in the following two years. In March 2016, I was appointed interim Chief Executive at Healthcare Improvement Scotland becoming the substantive Chief Executive in December 2016. I have held this role continuously since then. As Accountable Officer, I provide executive leadership for the organisation ensuring the delivery of organisational and national objectives. I was elected Vice Chair of the NHS Board Chief Executives Group in 2021 and served until 2023 becoming Chair in 2023 and demitted office in 2025. The role supports the collective leadership of the 22 NHS Board Chief Executives in devising cross-organisational responses to national initiatives and in informing Scottish Government policy. In my various roles since 1992, I cannot recollect being involved in matters related to the Neurosurgery Service at Ninewells Hospital.

2.3. In addition to that, I am currently on the board of Wheatley Care which is a subsidiary of the Wheatley Group. I have served as a lay member of the General Teaching Council for Scotland and as a trustee of the mental health charity, Penumbra.

2.4. I was not employed in the predecessor organisations of HIS referenced in the Inquiry's Terms of Reference, namely the Clinical Standards Board for Scotland (CSBS) and NHS Quality Improvement Scotland (NHS QIS). The names of key individuals formerly employed in NHS QIS and who were part of the CSBS have been provided to the Inquiry and those individuals may be in a position to provide the Inquiry with information about the actions taken by those organisations. On that basis, the responses to the questions below are primarily from the perspective of HIS, though I have referenced the evolution of CSBS and NHS QIS where I am able to do so.

2.5. As mentioned in our Opening Statement, I would like to recognise that many of Mr Eljamel's former patients and their families will be participating in or otherwise following this Inquiry. I wish to acknowledge the profound harm which has been sustained by them either directly or indirectly due to Mr Eljamel's actions. I would like to thank the Inquiry for the invitation to HIS to become a Core Participant and I, together with my colleagues at HIS, are willing to assist the Inquiry in any way that we can. I also give a commitment to taking forward the recommendations that may emerge from these proceedings which relate to the work undertaken by HIS.

Part B Structures and Key Individuals

3. Please provide an overview as to the role, function and responsibilities of HIS and its predecessor bodies over the relevant period, in particular with regard to functions of relevance to the provision of neurosurgical care at Ninewells Hospital, Dundee and in other hospitals under the control of NHS Tayside providing neurosurgical services. Please highlight any significant differences in the role and remit of these various bodies in that regard.

Healthcare Improvement Scotland (HIS)

3.1. On 6th November 2008, ministers announced the establishment of HIS, which would combine all the functions of NHS Quality Improvement Scotland (NHS QIS) with the registration and regulation of independent healthcare, which at the time was conducted by the Care Commission (now renamed the Care Inspectorate).

3.2. This transition took place on 1st April 2011, with HIS established by the National Health Service (Scotland) Act 1978, as amended by the Public Services Reform Scotland Act 2010 and the Public Bodies (Joint Working) Act 2014. NHS QIS was dissolved under the NHS Quality Improvement Scotland (Dissolution) Order 2011 and HIS effectively 'replaced' NHS QIS.

3.3. HIS is the national improvement agency for health and care in Scotland. The organisation's core purpose is to enable the people of Scotland to experience the best quality health and social care, with a specific focus on safety.

3.4. At the outset of HIS, it is important to note that like NHS QIS it was constituted with a range of functions from predecessor bodies. However, perhaps the most immediate difference was the general strengthening of the alignment of accountability for functions more explicitly to the Chief Executive, and the gradual integration of these functions into the wider organisation such as the Scottish Health Council and the Healthcare Environment Inspectorate.

3.5. HIS is established as a body corporate (as set out in Schedule 16 of the Public Service Reform (Scotland) Act 2010) and although it is not a special health board, it may be grouped with NHS special health boards in terms of Scottish Government initiatives such as shared services.

3.6. HIS's statutory functions are set out in the aforementioned legislation. HIS's key statutory duties are as follows:

- A general duty of furthering improvement in the quality of health care;
- A duty to provide information to the public about the availability and quality of services provided under the health service;
- When requested by Scottish Ministers, a duty to provide to Scottish Ministers advice about any matter relevant to the health service functions of HIS.

3.7. Specifically, under our operating framework with Scottish Government (see paragraph 7) [HIS-00007] HIS is to exercise the following functions of Scottish Ministers:

- To support, ensure, and monitor the quality of healthcare provided or secured by the health service;
- To support, ensure, and monitor the discharge of the duty on NHS boards to encourage public involvement;
- To evaluate and provide advice to the health service on the clinical and cost effectiveness of new and existing health technologies including drugs.

3.8. HIS has the following statutory powers:

- To enter and inspect premises in relation to inspecting independent healthcare services;
- A limited regulatory power since 2016 to direct a health board to close a ward to new admissions where there is a serious risk to the life, health, or wellbeing of persons as a safety measure of last resort;

- Power to require documents in relation to the functions of the Death Certification Review Service;
- Regulatory powers in relation to the independent healthcare sector;
- To require health boards to give such assistance to HIS as it requires (e.g. to provide information) in relation to its functions under the Health and Care (Scotland) Staffing Act (2019).

3.9. In delivering these functions there is an expectation that HIS will review and inspect the quality of healthcare in any service both in NHS Scotland and the independent sector, based on intelligence and evidence and at a time and manner of its choosing; this applies to both one-off reviews and planned programmes of assurance.

3.10. HIS is not a health care provider. Nor is HIS responsible for the performance management of any NHS or social care body which does provide care. We were not established to have any direct role in the management of the performance of individual clinicians.

3.11. We scrutinise and assure the safety and quality of NHS services in Scotland. This is not regulation. As a scrutiny body we carry out oversight and improvement, reviewing, inspecting, and making recommendations for change. A regulator will focus on control and legal compliance, with powers to enforce, licence or impose sanctions for non-compliance. HIS has a regulatory function under the IRMER (Ionising Radiation (Medical Exposure) Regulations) which are designed to ensure safe use of ionising radiation in medical settings. NHS Scotland service providers are ultimately accountable to the Scottish Cabinet Secretary for Health and Social Care through established governance mechanisms.

3.12. HIS's main functions are the independent assurance of the quality of care in Scotland, national improvement and redesign support for health and care services, and independent assessment of evidence to underpin high quality care. We work in partnership with health and care staff, with citizens and communities at the heart of change. Specialist teams across the organisation deliver these functions, often with cross-organisational working, through an extensive work programme aligned with [HIS-00001].

3.13. As explained above, HIS has no responsibility for the provision of healthcare services including neurosurgical care services at NHS Tayside. As far as I am aware, HIS has had no involvement with neurosurgical care services at NHS Tayside due to the fact that we have not received any intelligence or evidence in relation to this service or activities of Mr Eljamel. We were also not asked to review this service by the Scottish Ministers. Scottish government officials did approach us in 2023, and this is explained further at paragraph 13.1.

Predecessor Body - Clinical Standards Board for Scotland (CSBS)

3.14. The Clinical Standards Board for Scotland Order 1999 came into effect on 1 April 1999, establishing CSBS as a special health board with functions in relation to quality assurance and accreditation. Its creation fulfilled one of the recommendations of the 1998 Acute Services Review Report, which called for the introduction of what the report called a 'National Standards Group' to take responsibility for the process of reviewing and accrediting the services provided by the NHS in Scotland.

3.15. The main responsibility of the CSBS was to monitor clinical activity in NHS trusts. However, it was also involved in accreditation in primary care via a primary care reference group working in partnership with the Royal College of General Practitioners Scotland and other primary care organisations. The aim was for the CSBS to approve practice accreditation schemes managed by the college.

3.16. The role of CSBS was to:

- Promote public confidence that the services provided by the NHS were safe and that they met nationally agreed standards;
- Demonstrate that within the resources available, the NHS was delivering the highest possible standards of care. CSBS developed a standard setting and review process in partnership with healthcare professionals and the public. This process complemented the legal duty of the board of each NHS body to monitor and improve the quality of healthcare which it provides to individuals (known as clinical governance).

3.17. A paper published in 2002 by the Clinical Standards Board for Scotland, Improving Clinical Care in Scotland, [HIS-00003] describes how CSBS developed, monitored, and reported on its standards.

3.18. I am unable to provide information in relation to how or if CSBS had any involvement with the neurosurgical care services at NHS Tayside. I would suggest that individuals employed by CSBS at the time are better placed to provide this information to the Inquiry. In relation to the differences between HIS and CSBS, I am not able to comment further than as detailed above. I would suggest that policy officers at Scottish Government who were involved at the time are better placed to provide this information to the Inquiry.

Predecessor Body - Health Technology Board for Scotland (HTBS)

3.19. The Health Technology Board for Scotland Order 2000 came into effect on 1 April 2000, establishing the HTBS as a special health board. The order conferred functions on the board in relation to the evaluation and provision of advice to NHS Scotland on the clinical and cost effectiveness of new and existing health technologies including drugs. The role of HTBS was to provide evidence-based advice to NHS Scotland on the clinical and cost effectiveness of new and existing health technologies, including drugs, and introduced the process of Health Technology Assessment (HTA) in Scotland.

3.20. Similar to my position in response at para 3.18 above, I am unable to provide information in relation to how or if HTBS had any involvement with the neurosurgical care services at NHS Tayside. I would suggest that individuals employed by HTBS at the time are better placed to provide this information to the Inquiry. In relation to the differences between HIS and HTBS, I am not able to comment further than as detailed above. I would suggest that policy officers at Scottish Government are better placed to provide this information to the Inquiry.

Predecessor Body - NHS Quality Improvement Scotland (NHS QIS)

3.21. A Parliamentary debate took place on Thursday May 16 2002. The Scottish Parliament Official Report [HIS-00002] gives insight into Scottish Government thinking about NHS reform at that time, prior to the establishment of NHS QIS.

3.22. NHS QIS was established in 2003, under the NHS Quality Improvement Scotland Order 2002. It was constituted as a special health board with a remit to improve the quality of healthcare in Scotland and followed the merging of five individual organisations.

3.23. Two of the five merged organisations were previous legal entities and were dissolved by the NHS Quality Improvement Scotland Order 2002. These were the Clinical Standards Board for Scotland (CSBS) and the Health Technology Board for Scotland (HTBS), outlined below. The remaining three were moved from Scottish Government. These were the Clinical Resource and Audit Group (CRAG), Nursing and Midwifery Practice Development Unit (NMPDU), and Scottish Health Advisory Service (SHAS). Scottish Government will be able to provide further details about the policy context at the time which underpinned the establishment of NHS QIS.

3.24. The purpose of NHS QIS was to improve the quality of healthcare in Scotland by delivering on five key functions:

- Providing advice and guidance on effective clinical practice
- Setting clinical and non-clinical standards of care
- Reviewing and monitoring NHS services
- Supporting staff in improving services
- Promoting patient safety
- Implementation of clinical governance.

3.25. NHS QIS was expected to coordinate the work of Scotland's clinical effectiveness organisations through the development of a national strategy for improving the quality of patient care. It also advised NHS Scotland on the clinical and cost effectiveness of new and existing health technologies.

3.26. The following became functions of NHS QIS after its establishment and are now functions of HIS.

3.26.1. **Scottish Intercollegiate Guidelines Network:** The Scottish Intercollegiate Guidelines Network (SIGN) became part of NHS QIS in 2005. SIGN was established in 1993 by the Academy of Royal Colleges and their Faculties in Scotland, to develop evidence-based clinical guidelines for the NHS in Scotland. The membership of SIGN includes all the medical specialties, nursing, pharmacy, dentistry, professions allied to medicine, patients, health service managers, social

services, and researchers. Under the transfer agreement with the Academy and NHS QIS, SIGN retained editorial independence in relation to the guidelines it produced. All SIGN staff are employed by Healthcare Improvement Scotland (formerly NHS QIS), and the SIGN programme is supported by core funding from Healthcare Improvement Scotland and the SIGN team are part of the Evidence and Digital Directorate of HIS;

3.26.2. **Scottish Health Council:** The NHS Quality Improvement Scotland (Establishment of the Scottish Health Council) Regulations 2005 placed a duty on NHS QIS to establish a committee to be known as the Scottish Health Council and to delegate to the SHC the function of supporting, ensuring and monitoring the discharge of the duty under (i) section 2B of the National Health Service (Scotland) Act 1978 (c. 29) ("the Act") (duty to encourage public involvement) and (ii) section 2D of the Act (duty to discharge functions in a manner that encourages equal opportunities and in particular the observance of the equal opportunity requirements) by health boards, special health boards and the Common Services Agency for the Scottish Health Service. The SHC is now a governance committee of HIS;

3.26.3. **Healthcare Environment Inspectorate:** The Healthcare Environment Inspectorate was established in 2009 with a remit to reduce the risk of Hospital Acquired Infections (HAI) in acute hospitals through assessment, inspection, and reporting of boards' performance against HAI standards. This function is now undertaken by HIS more broadly through its inspection function.

3.27. To the best of my knowledge and recollection, there is no correlation between the work of HIS, SIGN, the Scottish Health Council, or the earlier Healthcare Environment Inspectorate and the Terms of Reference of this Inquiry in relation to neurosurgical provision.

3.28. I am unable to comment on whether there was any role for NHS QIS in relation to neurosurgical provision, as that is best answered by those individuals who were employed by NHS QIS, or the policy officials at Scottish Government responsible for its establishment. The names of some individuals who may be able to provide evidence in this regard are detailed at paragraph 9.1.

The Scottish Council for Postgraduate Medical and Dental Education

3.29. The request for evidence refers to the Scottish Council for Postgraduate Medical and Dental Education as a "predecessor body." It is understood that this was a predecessor body of NHS Education for Scotland, not HIS, therefore we are unable to comment.

4. When and why did the body with responsibility for healthcare improvement in Scotland change as it did over the relevant period?

4.1. The Scottish Government of the day made the decisions about what was required within NHS Scotland, setting the policy direction and drafting legislation to determine the roles of HIS and each of the predecessor organisations, at the times previously set out in response to question 3 above.

4.2. Paragraph 176 of the Policy Memorandum [HIS-00004] that accompanied the Public Services Reform (Scotland) Bill which established HIS stated amongst its policy aims that: "The structural changes will assist in achieving improvements to scrutiny, the creation of a cohesive system for improvement and scrutiny, simplification of the public sector and therefore improvement to public services."

5. What were the key structural differences in the way in which each of these bodies was able to play a function in healthcare improvement in Scotland? How did these differences impact on the ability of these bodies to play a meaningful role in the provision of neurosurgical care at Ninewells Hospital, Dundee and in other hospitals under the control of NHS Tayside providing neurosurgical services?

5.1. The key differences in the purposes between the organisations are defined in the legislation, although ultimately the objective continued to be to improve the quality of care experienced by patients. Looking at the extent of the functions set out in legislation, neither HIS nor its predecessor bodies were established with a direct responsibility for the actions or behaviours of clinicians employed by the health boards. That is something for the employers and the governing professional bodies.

5.2. I am unable to describe the structural differences for the predecessor organisations, or whether this impacted on their ability to play a meaningful role in the provision of neurosurgical care at NHS Tayside, as I have no knowledge of what structure those predecessor organisations would have had in place.

5.3. We are principally concerned with looking at the quality and safety of the healthcare system, and systemic improvement challenges. Speaking for my own organisation, I would say that if we were to learn of something of concern, we would wish to consider the implications for the safety of patient care and take appropriate action, sometimes in conjunction with other agencies, or escalate appropriately to professional regulatory bodies.

6. Please explain the extent to which HIS retains legal or regulatory responsibility for the actions of its predecessor bodies which performed similar roles over the relevant period. To the extent that HIS does not retain such responsibility, please explain what bodies do retain such legal or regulatory responsibility.

6.1. HIS was created in 2011 and is a different body from CSBS and NHS QIS, although as mentioned earlier it did by statute, inherit certain functions of those bodies as set out in paragraph 3.6.

6.2. HIS has responsibility for the regulation of independent healthcare, which was previously conducted by the Care Commission as set out in paragraph 12.4.

6.3. I am unable to comment on where the legal responsibility sits for acts or omissions by organisations that predate the one I am responsible for. This raises questions about the interpretation of the legal framework which others may be better qualified to consider and address.

7. Please explain the extent to which HIS retains access to documents held by or on behalf of its predecessor bodies, with relevant or potential relevance to the matters covered by the Inquiry's Terms of Reference and List of Issues. If possible, please explain (a) whether any other bodies have access to or are likely to have access to any such documents (b) to the extent that such documents are not retained, any reasons why they have not been.

7.1. HIS has maintained the official records of its Board and Committee meetings since inception and can make these available to the Inquiry. We have reviewed these documents electronically using key word searches of Eljamel, neurosurgery and neurology. We did not identify anything of relevance to the Inquiry Terms of Reference as a result of our search.

7.2. With respect to its predecessor bodies, HIS has included these bodies within its search for relevant documents described in Part E below. We do hold a number of electronic records from governance meetings held by NHS QIS. We have retained within our archive a set of NHS QIS Board papers and minutes dating from 3 February 2005 to 24 February 2011. This appears to be a comprehensive set. We have conducted an electronic key word search for the terms of Eljamel, Neurology and neurosurgery and have not identified any documents containing these words. It is not possible for us to comment on the potential wider relevance to the Inquiry's Terms of Reference, but individuals who were part of the NHS QIS Executive Team or Board would be better placed to understand any potential relevance.

7.3. We have also identified some official publications produced by predecessor bodies that we hold in hard copy or electronic format. The titles of these documents have been searched, and we have provided a list [HIS–00022] for the ones we believe may be of interest to the Inquiry. Beyond identifying the titles, we are unable to comment on their relevance to the Inquiry. Our search has also included searching the catalogues of the National Library of Scotland and National Records of Scotland. We looked at the titles of documents held in those catalogues and did a text search of key words "Eljamel," "Neurology" and "neurosurgery." These searches brought back no positive results. We do not believe those documents have any relevance to the Inquiry's Terms of Reference.

7.4. We have addressed the issue of records we hold in the response to Section E of this statement.

8. **Please provide an explanation of the areas related to the care of Mr Eljamel's neurosurgical patients in which HIS or its predecessor bodies (a) had exclusive responsibility; and (b) had shared competence with other government departments, agencies, public or private bodies over the relevant period for systems relating to the provision of neurosurgical care at Ninewells Hospital, Dundee and in other hospitals under the control of NHS Tayside providing neurosurgical services. As**

regards (b) please set out how HIS or its predecessor bodies' responsibilities overlapped or interacted with the responsibilities of those other bodies in that regard.

8.1. The role of HIS did not extend to the direct care of Mr Eljamel's neurosurgical patients. My understanding is that neither did the predecessor bodies have such responsibility, although the key senior personnel from those predecessor bodies may be better placed to respond on this point.

8.2. HIS was established with the statutory duties set out in the answer to question 3 above. Its focus is on improving systems for the safe delivery of healthcare, rather than on the provision of care or treatment to individual patients, or on the practice of individual healthcare professionals, unless these matters taken in the wider context indicate systemic issues.

8.3. Managing the performance of clinicians is the responsibility of the employing NHS Board and there are separate bodies with responsibility for regulating healthcare professionals. NHS Boards are ultimately accountable to the Scottish Government Cabinet Secretary for Health and Social Care through well-established performance management and escalation processes.

8.4. During the relevant period, HIS would not have been the correct body for anybody wishing to highlight a complaint or concern about Mr Eljamel or the care of his patients, given the responsibilities of other bodies referred to above.

8.5. Complaints or concerns about individual clinicians should generally in the first instance be raised with the employing NHS Board. However, such matters may reflect wider concerns about the systems of governance within an NHS Board – including safety. While our processes within HIS are not designed for responding to a complaint or concern about a clinician, we would certainly act on any information we heard. For example, if something was brought to our attention through the responding to concerns process, we would notify the relevant bodies, those being the employing health board and/or the professional governing body. Where there are systemic matters relating to patient care, depending on the nature of the issue, that may be a matter for our response by way of an inspection visit.

8.6. As explained in paragraph 8.1, HIS is not responsible for the systems relating to the provision of neurosurgical care within NHS Tayside nor any other Health Board. As far as I am aware, HIS does not share competence with any other government departments, agencies, public or private bodies as I am not aware of any other body having the same statutory functions as HIS in relation to NHS Scotland or the regulation of independent healthcare. I am unable to comment on the extent any predecessor body had shared competence and would suggest key senior personnel from those predecessor bodies, may be better placed to respond on this point. Details of relevant individuals are contained in paragraph 9.1.

9. Please provide a high-level overview of the structure of HIS and its predecessor bodies and a list of key individuals and their roles within HIS and its predecessor bodies over the relevant period, insofar as relevant to the neurosurgical service provided by it and the matters covered by the Inquiry's Terms of Reference and List of Issues by way of organogram, if necessary.

9.1. We have previously provided names of key individuals who will be able to provide evidence relating to the institution of NHS QIS and CSBS, the work of these bodies and the policy changes that led to their dissolution and the establishment of HIS. That evidence may assist the Inquiry in understanding the rationale behind the institution of HIS and how that correlates with its current role. Again, that is likely to assist the Inquiry in fulfilling Terms of Reference 6 (b) and 18. I am not in a position to explain what evidence those individuals may be able to provide. For completeness, the names of those individuals we believe may be able to further assist the Inquiry are detailed below:

- Former Chairs of NHS QIS, Sir Graham Teasdale (2006-2011) and Lord Naren Patel (2003-2006);
- Former Chief Executives of NHS QIS, Dr Frances Elliot (2009 until the establishment of HIS in 2011, and Chief Executive of HIS from 2011-2013) and David Steel (2003-2009);
- Angiolina Foster, former Chief Executive of HIS (2014-2016);
- Jan Warner, former Director of Patient Safety and Performance Assessment, QIS (2003-2011);
- Gerry Marr former non-executive director HIS (2011-2013);

- Senior civil servants at Scottish Government at the time HIS was established including Andrew McLeod, Deputy Director; and
- The current Sponsor team for HIS at Scottish Government

9.2. Healthcare Improvement Scotland at its inception designed a new organisational structure that was intended to consolidate leadership in key senior roles reporting to the Chief Executive. The direct reports in the new structure were: Executive Clinical Director; Director of Evidence and Improvement; Director of Scrutiny and Assurance; and Director of the Scottish Health Council. Individuals were appointed to the roles – aside from Director of the Scottish Health Council – in the early part of 2012.

9.3. The minute of the first Board meeting [HIS-00005] held by HIS on 27 April 2011 provides the names and roles of the personnel who directly reported to the Chief Executive at that time. From those minutes, the names of those in attendance at the meeting were:

Board Members resent at the meeting were: Dr D Coia (Board Chair); Dr H Wilson CBE (Vice Chair), Dr F Elliot (Chief Executive and executive member of the Board) and non-executive members Prof F Clark CBE (Chair of the Care Inspectorate); Mr M Fuller MBE; Ms N Gallen; Mr H Hamill CB; Cllr P Johnston; Mr G Marr; Dr R Masterton; Prof Sir L Ritchie OBE; Mr D Service; Mrs P Whittle CBE.

Also in attendance at the meeting were: Susan Brimelow Chief Inspector, Healthcare Environment Inspectorate; Ms Hilary Davison Acting Director of Guidance & Standards; Mr Adrian Masson Head of Corporate Secretariat; Mr Anthony McGowan Human Resources Manager (Deputising for Head of Human Resources); Ms Margo McGurk Head of Finance; Ms Eileen Moir Director of Nursing/ Co-Director of Implementation and Improvement Support; Mr Richard Norris Director, Scottish Health Council (SHC); Ms Pat O'Connor Deputy Chief Executive; Dr Brian Robson Medical Director; Ms Jan Warner Director of Patient Safety & Performance Assessment; Mrs Gwen Johnstone Corporate Services Officer (Minute Secretary); Apologies: Ms Marion Keogh; Mr Ken Miller Head of Communications; Ms Kathlyn McKellar Head of Human Resource.

9.4. Subsequently, in 2014, the Director of Evidence and Improvement role was split into two roles: Director of Improvement Support and Director of Evidence. Since then,

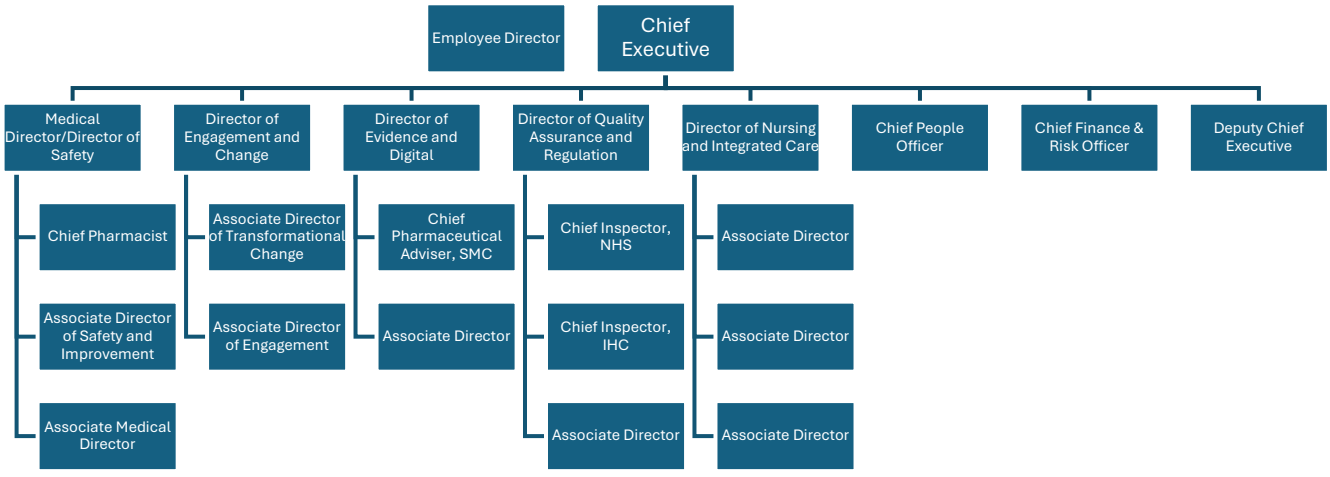
there have been several other changes to the design of the senior leadership structure including the appointment of a Director of Nursing, Midwifery and AHPs in 2017 and Medical Director in 2020.

9.5. Membership of the current HIS Board and Executive Team are available on the HIS website. [HIS-00006] No member of the HIS Board or Executive Team has direct responsibility for the provision of neurosurgery or matters relating directly to the Inquiry's Terms of Reference. The current Board members of HIS are:

- Chair, Evelyn McPhail;
- Myself, Chief Executive, Robbie Pearson;
- Non-executive Board Members: Vice Chair and Chair of Scottish Health Council, Suzanne Dawson; Dr Abishek Agarwal; Keith Charters; Nicola Hanssen; Dr Nicola Maran; Doug Moodie; Michelle Rogers; Duncan Service (Employee Director, also a member of the Executive Team); Robert Tinlin; Judith Kilbee; John Lund; and
- Chair on secondment 2025-26 Carole Wilkinson.

9.6. At the time of writing the Executive Directors in addition to myself and Duncan Service are Deputy Chief Executive Ann Gow; Director of Quality Assurance and Regulation Eddie Docherty; Director of Engagement and Change Clare Morrison; Director of Evidence and Digital, Safia Qureshi; Medical Director and Director of Safety Simon Watson; Director of Nursing and Integrated Care Melissa Dowdeswell.

9.7. The current structure of the senior team within HIS that make up its recently established Performance and Delivery Board is as follows:



10. Please explain how the role of HIS and its predecessor bodies over the relevant period fitted with the role/ remit of the following key organisations which did or could have had a role in the oversight of aspects of the professional practice of Mr Eljamel: (a) NHS Tayside or its predecessor organisations; (b) The Scottish Executive/ Scottish Government; (c) Insofar as relevant to the provision of healthcare over the relevant period, the UK Government; (d) NHS Education for Scotland and its predecessor organisations; (e) The Department for Medical Education; (f) The University of Dundee; (g) The Royal College of Surgeons (Edinburgh); 13 (h) The Royal College of Surgeons; (i) The General Medial Council; (j) The British Medical Association; (k) The Health and Safety Executive; and (l) Any other bodies which held a remit relevant to matters falling with the Inquiry's Terms of Reference.

(a) NHS Tayside or its predecessor organisations;

10.1. HIS has a role in improving the quality of care in the NHS. It ensures healthcare services, rather than individual clinicians, meet expected standards of practice. It conducts its role through the provision of external assurance, evidence, and improvement support. In doing so, its focus is on the provision of services by the 14 NHS boards, including NHS Tayside. The scope of this is agreed annually with the Scottish Government through the Annual Delivery Plan and the specific annual Quality Assurance and Regulation Plan. The role of HIS does not extend to the oversight of aspects of the professional practice of individual clinicians and accordingly did not extend to Mr Eljamel.

(b) The Scottish Executive/ Scottish Government;

10.2. As a health body established under the Public Service Reform (Scotland) Act 2010, HIS is accountable to Scottish Ministers.

10.3. HIS Chief Executive is accountable to the HIS Board Chair and the Board Chair is accountable to Scottish Ministers. HIS is accountable to Scottish Ministers via the Scottish Government Sponsor Function for the delivery of its strategic objectives.

10.4. HIS and its predecessor organisation, NHS QIS, had in place formal arrangements to support their working relationship with Scottish Government, such as regular meetings between senior officials and annual accountability reviews. The HIS-

Scottish Government Operating Framework, developed in 2019, sets out how HIS works with the Scottish Government. [HIS-00007]

10.5. The HIS Scottish Government Operating Framework [HIS-00007] is the primary accountability and governance document between HIS and Scottish Government and is available on the HIS website. It is regularly reviewed and updated, and the next iteration is expected to be agreed in 2026.

10.6. Whilst overall objectives are agreed with Scottish Government, HIS acts independently of the Scottish Government and Ministers in exercising its powers.

(c) Insofar as relevant to the provision of healthcare over the relevant period, the UK Government;

10.7. As HIS operates as part of the devolved system of the management of the NHS, it does not have a direct relationship with the UK Government. It does have a relationship with arms-length bodies which operate either on behalf of the UK as a whole (i.e. reserved matters) such as the Medicines & Healthcare Products Regulatory Agency (MHRA) or bodies that are arms-length of the Department of Health in England such as the National Institute for Health and Care Excellence (NICE), and in such instances where there is the sharing of knowledge and expertise.

(d) NHS Education for Scotland and its predecessor organisations;

10.8. At the request of the Scottish Government, HIS set up a programme of annual review of medical appraisal and revalidation in Scotland building on preparatory work undertaken by NHS QIS and commenced the first review in 2012. The annual review programme continued for five years and after publication of the 2016- 2017 report the responsibility for undertaking this process was passed to [HIS-00038] NHS Education for Scotland (NES).

10.9. HIS has a close working relationship with NES. This entails the sharing of knowledge and intelligence in respect of the training environment of resident doctors (formerly junior doctors), which can reflect signals about the quality of healthcare. Both organisations are members of the Sharing Health and Care Intelligence Network (SHCIN) established in 2023, and its predecessor, the Sharing Intelligence

for Health, and Care Group (SIHCG), which met for the first time in April 2015. The SIHCG was established to bring together a range national bodies for the purpose of sharing and considering the intelligence we hold about the quality of health and social care. This infrastructure was established in direct response to the Francis Inquiry following the failures at Mid Staffordshire NHS Trust and the deficiencies in various bodies to share knowledge and intelligence. Further information and background to the SIHCG and SCHIN is provided in response to question 11(e) below.

10.10. SHCIN is underpinned by Sharing Health & Care Intelligence Network: A framework for sharing intelligence, which is an agreement approved by all members of the network. [HIS-00008]

10.11. HIS maintains a strong, long-standing partnership with NES to support training and the development of expertise in safety and quality improvement. This collaboration is delivered through national programmes led by NES, such as the Scottish Improvement Leaders Programme and the Scottish Quality and Safety Fellowship. These initiatives have played a vital role in building improvement capability across NHS Scotland. This way of working with NES is underpinned by a series of specific operating agreements tailored to each programme of work. For example, the Service Level Agreement between HIS and NES in relation to the delivery of the Scottish Improvement Leader Programme [HIS-00009].

(e) The Department for Medical Education;

10.12. No relationship.

(f) The University of Dundee;

10.13. No relationship.

(g) The Royal College of Surgeons (Edinburgh);

10.14. There is no formal relationship between HIS and the Royal College of Surgeons of Edinburgh (RCSEd), though RCSEd is a member of Scottish Intercollegiate Guidelines Network (SIGN) Council. There is a working relationship with HIS and a range of Royal Colleges, including RCSEd, and the Academy of the Medical Royal

Colleges in Scotland. It also includes the Scottish Academy representing all the Medical Royal Colleges and Faculties in Scotland. HIS has a permanent invitation to attend the Scottish Academy formal meetings (the federation of all Medical Royal Colleges & Faculties in Scotland). We attend as observers but are encouraged to contribute to agenda and discussion. We have done so recently on the subject of transparency of invited college reviews.

(h) The Royal College of Surgeons;

10.15. There are various interactions between HIS and the Scottish and UK Royal Colleges, including the Royal College of Surgeons, meaning we will be in touch with them from time to time on matters of mutual interest, for example we work with the Royal College of Surgeons to help us find external specialist medical advisors.

(i) The General Medical Council;

10.16. In recent years, the General Medical Council (GMC), alongside other professional regulators, has become a member of the Sharing Health and Care Intelligence Network. Outside of that, there is close ongoing liaison between the GMC and the Medical Director in HIS who routinely meets with the GMC Employee Liaison Adviser. These discussions have not, in my Medical Director's experience, been about concerns about working doctors, they are more usually about system safety and quality issues emerging from HIS's remit and shared interests with the GMC. For example, our work on mental health and maternity service inspections has been of interest to the GMC.

10.17. HIS also attends the General Medical Council UK Advisory Forum meetings in Scotland. There is also a Memorandum of Understanding between HIS and the GMC [HIS-00010].

(j) The British Medical Association;

10.18. There is on-going dialogue with HIS and the British Medical Association regarding matters affecting the medical workforce in NHS Scotland. This is not relevant to the Inquiry's Terms of Reference.

(k) The Health and Safety Executive; and

10.19. There is an established Memorandum of Understanding dated 2019 [HIS-00037] and an earlier 'letter of understanding' dated 2011 [HIS-00036] between HIS and the Health and Safety Executive which sets out matters to be escalated or information to be shared.

(l) Any other bodies which held a remit relevant to matters falling with the Inquiry's Terms of Reference.

10.20. We have no further comments to add in relation to other bodies.

11. Please explain the main principles of policies and practices governing the role of HIS and its predecessor bodies, including how these evolved over the relevant period, insofar as they were relevant or potentially relevant to the practice of Mr Eljamel, relating to: (a) Appointments of consultants over the relevant period, including but not limited to the process by which consultants' professional qualifications and competence are verified (ToR 1); (b) Broad systems of clinical governance, in place over the relevant period and how they evolved, including corporate governance, professional governance and whistleblowing (ToR 3); (c) Broad systems and rules about work patterns within the NHS, balancing work between the NHS and the private sector (ToR 2/ 3) and about supervision/ training of junior colleagues (ToR 2); (d) Complaints and feedback systems within the NHS (ToRs 4 and 5); (e) Internal and external information sharing systems, candour, including with the GMC (ToRs 7 and 13); (f) Rules and practices relating to clinical supervision, suspension, dismissal and removal of the name of a neurosurgeon from the GMC medical register (ToRs 8 to 11); (g) Investigations undertaken into the professional practice of consultants in the NHS in Scotland over the relevant period, such as those covered by ToR 12; (h) The creation and maintenance of effective document management systems within health boards such as NHS Tayside over the relevant period and subsequently (ToR 14); or 14 (i) Any other matters falling within the ambit of the Inquiry's Terms of Reference or provisional List of Issues.

11.1. Whilst not all falling within the relevant period, or being directly relevant to the Inquiry's work, the responses below are included as they may be of interest to the Inquiry.

(a) Appointments of consultants over the relevant period, including but not limited to the process by which consultants' professional qualifications and competence are verified (ToR 1);

11.2. HIS does not have a role in relation to the appointment of consultants or oversight of the practice of individual clinicians within NHS Boards.

11.3. At the request of the Scottish Government, HIS set up a programme of annual review of medical appraisal and revalidation in Scotland building on preparatory work undertaken by NHS QIS and commenced the first review in 2012 [HIS-00011]. As already referred to in paragraph 10.8, the annual review programme continued for five years and after publication of the 2016-2017 report, [HIS–00038] the responsibility for undertaking this process was passed to NHS Education for Scotland (NES).

(b) Broad systems of clinical governance, in place over the relevant period and how they evolved, including corporate governance, professional governance and whistleblowing (ToR 3);

11.4. HIS provides a range of guidance, tools and frameworks that enable healthcare professionals to deliver care that is safe, effective, and person-centred. This is achieved through several key approaches, including the development and implementation of guidelines and standards, such as those for infection prevention and control, and the creation and dissemination of structured frameworks. Examples include the Quality Assurance Framework [HIS-00012] which supports systematic evaluation and improvement, and the Essentials of Safe Care [HIS-00013], which outline core practices to ensure patient safety. These documents are submitted because they are good examples which illustrate the role of our organisation within NHS Scotland and the approach our organisation takes to scrutiny, assurance and improving patient safety. Together these tools guide organisations and practitioners in embedding best practice, reducing variation, and fostering a culture of continuous improvement across health and social care services.

11.5. Work is underway to develop clinical governance standards, and we published our draft standards in July 2025 [HIS-00014]. We aim to publish the final version of the new standards by March 2026.

Whistleblowing: Responding to Concerns programme (up to 2015)

11.6. In April 2013, Scottish Government launched the National Confidential Alert Line (NCAL). This was a free, confidential telephone line to allow NHS employees to raise any concerns about practices in NHS Scotland. The alert line would pass any concerns raised by employees on to the employer or the relevant regulatory organisation for investigation. HIS was identified by Scottish Government as one of the relevant organisations. An internal process (NCAL process) was developed to review, respond and manage any referrals that were received in relation to patient safety or quality of care of NHS services.

11.7. The Public Interest Disclosure Act 1998 (PIDA) is the law that protects whistleblowers from negative treatment or unfair dismissal from raising a concern (also known as a protected disclosure). Although staff should be able to raise concerns in their own organisation, the law also enables staff to raise concerns with 'prescribed persons.' In 2014, HIS was designated a 'prescribed person' in the Public Interest Disclosure (Prescribed Persons) Order 2014. This means that it a statutory duty to respond to concerns raised/referred to us that have the potential to impact on safety or quality of care within the NHS in Scotland. As a designated prescribed person, individuals can come directly to HIS to raise concerns and still be entitled to the protection detailed within the Act.

Current Responding to Concerns (RTC) Programme

11.8. HIS continues to assess concerns relating to the safety and/or quality of patient care under PIDA. It also now considers concerns referred to it by other national organisations. The RTC process is not designed to investigate individual patient care or isolated incidents. It considers the concerns raised within the context of the relevant systems and processes, and the potential impact on patient safety or quality of care in the delivery of that service. The aim is to establish if the NHS board is aware of the concerns, to assess how they are responding to the concerns, including any actions and improvements that are being put in place, and what governance and oversight arrangements are in place to ensure there is appropriate pace and momentum in taking forward necessary actions. HIS gathers relevant intelligence internally from relevant teams across the organisation and externally from relevant national organisations to inform the assessment process.

11.9. HIS does not have a remit to consider complaints or concerns from members of the public about NHS services. Members of the public can raise a complaint about their treatment or access (or where appropriate someone else's) to healthcare directly with the local NHS board or GP surgery. Information about making a complaint is available through NHS Inform or contacting the relevant NHS board.

11.10. Concerns and complaints about independent healthcare services are not within the remit of the RTC programme. These are responded to and managed by the HIS Independent Healthcare team [HIS-00015].

(c) Broad systems and rules about work patterns within the NHS, balancing work between the NHS and the private sector (ToR 2/ 3) and about supervision/ training of junior colleagues (ToR 2);

11.11. HIS did not have a role in relation to these matters within the relevant period being investigated by the Inquiry. However, it may be of interest to the Inquiry to note that HIS has a role in relation to the Health and Care Staffing (Scotland) Act 2019, which came into effect in April 2024. This includes working with NHS Boards in a range of ways to improve workload and workforce planning to meet their obligations under the Act.

11.12. Under the Act, NHS Scotland boards are legally required to be appropriately staffed. This is in order to provide safe, high quality care. This aims to improve outcomes for service users and put patient safety at the fore.

11.13. The purpose of the Healthcare staffing operational framework is to underpin the Healthcare Improvement Scotland and Scottish Government operational framework.

11.14. It will:

- clearly define key roles and responsibilities of HIS's Healthcare Staffing Programme (HSP) and the wider organisation in meeting HIS's legislative duties
- clearly define when and how HIS will consult with wider stakeholders to meet its legislative duties

- set out when and how HIS will make recommendations and report to Scottish Ministers and where appropriate publish the findings of any review
- provide the necessary governance

11.15. More Information about our Healthcare Staffing Programme [HIS-00016] is available on the HIS website.

(d) Complaints and feedback systems within the NHS (ToRs 4 and 5);

11.16. HIS has a statutory role to support, ensure and monitor the discharge of the duty on NHS Boards to encourage public involvement. In April 2014, it published a report titled Listening and Learning: How Feedback, Comments, Concerns and Complaints Can Improve NHS Services in Scotland [HIS-00017]. This report set out progress made by NHS Boards in meeting legal rights and duties enabling people to give feedback, make comments, raise concerns, and make complaints about that were introduced in the Patient Rights (Scotland) Act 2011.

(e) Internal and external information sharing systems, candour, including with the GMC (ToRs 7 and 13);

Sharing Intelligence for Health and Care Group

11.17. The importance of sharing and acting upon data and information about the quality of care has been recognised as an essential component in delivering high quality health and social care. As well as including the sharing of information at the point where care is provided, this also applies to the sharing of intelligence between national agencies.

11.18. For example, recommendation 35 from the Mid Staffordshire NHS Foundation Trust Public Inquiry [HIS–00035_89] states that there should be better sharing of all intelligence between regulators which, when pieced together, would raise the level of concern. In addition, as we understand it, there was a publication entitled ‘National Information & Intelligence Framework for Health & Social Care for Scotland: 2012-2017’. We do not unfortunately hold a copy and do not know which organisation would still hold a copy.

11.19. In Scotland, there were several national organisations that, between them, held a considerable amount of data and information about the quality of health and social care. However, prior to April 2015, there was no ready mechanism that enabled these organisations to draw together and consider this collective data and information. This meant that no one organisation had a sufficiently complete picture of the quality of health and social care, and we were not making best use of our collective intelligence to inform delivery of our distinct roles and responsibilities. In response to this, the Sharing Intelligence for Health and Care Group (SIHCG) was established to bring together several national bodies for the purpose of sharing and considering the intelligence we hold about the quality of health and social care.

11.20. The SIHCG met for the first time in April 2015 [HIS–00041] and included representation from the following six national organisations:

- Audit Scotland,
- Care Inspectorate,
- Healthcare Improvement Scotland,
- Mental Welfare Commission for Scotland,
- NHS Education for Scotland, and
- Public Health & Intelligence.

11.21. The SIHCG provided a mechanism [HIS–00042] and [HIS–00043] for these agencies to share and consider their collective data and information about health and social care providers and have an active dialogue about the quality of health and social care. Specifically, the aims of the group were to:

- provide a forum to identify potential or actual risks to the quality of health and social care and, where necessary, initiate further action in response to these risks, and
- promote co-ordination of activity between these partner organisations, respecting the statutory responsibilities of each.

11.22. During 2015–2016, its first full year of operation, the SIHCG met six times, to share and discuss intelligence relating to 14 territorial NHS boards and two special boards that provide frontline care. The group considered 2-3 boards at each meeting. Both quantitative and qualitative data and information were provided by each member of the group and collated into a combined intelligence and interpretation document and

that was considered at each meeting. However, the intelligence provided did not identify individual members of the public or care professionals.

11.23. The SIHCG met to discuss combined intelligence about NHS Tayside in August 2015 [HIS-00018].

Establishment of Sharing Health and Care Intelligence Network

11.24. The Sharing Health and Care Intelligence Network (SHCIN) [HIS–00008] replaced the SIHCG and has been operating since June 2023. The SHCIN provides a forum for national organisations with a scrutiny or improvement role at system/service level, professional regulators, and improvement/training bodies to come together to share intelligence, present analysis and have collective discussion regarding potential emerging issues related to safety and quality of care.

11.25. The key purpose of the SHCIN is to bring together national organisations with a scrutiny or improvement role at system/service level, professional regulators, and improvement/training bodies to share, consider, and respond to intelligence on emerging issues relating to safety and quality of care in the health and care system. This activity helps agencies within the SHCIN discharge their responsibilities to support safe and high-quality care in Scotland.

11.26. The SHCIN provides a trusted, safe space for sharing information and intelligence at a systems level with a focus on identifying risks of serious failures in services. Meeting agendas focus on prioritisation of emerging issues which supports a more agile and responsive approach to addressing emerging issues and taking early action on new risks as individual network members or as a collaborative across the SHCIN.

11.27. The information and intelligence shared by SHCIN members are directed at a systems level to support a better understanding of the safety and quality of health and care services and the high-impact opportunities for improvement.

11.28. SHCIN members are:

- Audit Scotland
- Care Inspectorate

- General Chiropractic Council
- General Dental Council
- General Medical Council
- General Optical Council
- General Osteopathic Council
- General Pharmaceutical Council
- Healthcare Improvement Scotland
- Health & Care Professions Council
- Mental Welfare Commission Scotland
- NHS Education for Scotland
- Nursing and Midwifery Council
- Public Health Scotland
- Scottish Public Service Ombudsman
- Scottish Social Services Council.

(f) Rules and practices relating to clinical supervision, suspension, dismissal, and removal of the name of a neurosurgeon from the GMC medical register (ToRs 8 to 11);

11.29. HIS has developed a Registered Healthcare Professionals: Fitness to Practice Referral Process dated June 2024 [HIS-00019]. This sets out steps that HIS will take where significant concerns, intelligence or behaviours are identified in respect of a registered healthcare professional working out-with HIS and either within NHS Scotland, a regulated independent healthcare service or an unregulated service. This process involves discussion with the relevant professional lead within HIS and may result in a Fitness to Practice referral to the relevant professional body, which could be the GMC.

(g) Investigations undertaken into the professional practice of consultants in the NHS in Scotland over the relevant period, such as those covered by ToR 12;

11.30. Matters covered in (f) and (g) above are primarily matters for the employing NHS Board and the GMC. As the employer, the Board is responsible for day to day clinical governance, ensuring consultants practice safely and competently, and managing performance, conduct and managing any disciplinary matters. The GMC as the professional regulator is responsible for a consultant's fitness to practice, and for

investigating serious professional misconduct or clinical failings. Healthcare Improvement Scotland reviews systems, services, and organisational matters, it does not intervene with individual consultants.

(h) The creation and maintenance of effective document management systems within health boards such as NHS Tayside over the relevant period and subsequently (ToR 14);

11.31. Document management systems within health boards are primarily a matter for those boards, although where relevant, HIS may comment on specific aspects of record keeping where relevant in its inspections or reviews. During an inspection visit we may access patients' health records, monitoring reports, policies, and procedures, and what we find may result in either a requirement or a recommendation. Requirements must be addressed in a follow up action plan from the NHS Board. For example, after one inspection we previously conducted at an acute hospital we stated that the hospital would be required to ensure that all patient documentation was accurately and consistently completed with actions recorded, including, for example, falls risk assessments.

(i) Any other matters falling within the ambit of the Inquiry's Terms of Reference or provisional List of Issues.

11.32. We will keep these under review as the work of the Inquiry progresses.

Part C Involvement of HIS or its predecessor bodies with the professional practice of Mr Eljamel

12. How might concerns regarding Mr Eljamel's professional practice have been brought to the attention of HIS or its predecessor bodies?

NHS Scotland

12.1. Managing the performance of clinicians is the responsibility of the employing NHS Board and there are separate bodies with responsibility for regulating healthcare professionals. NHS Boards are ultimately accountable to the Scottish Government Cabinet Secretary for Health and Social Care through well-established performance management and escalation processes.

12.2. During the relevant period, HIS would not have been the correct body for anybody wishing to highlight a complaint or concern about Mr Eljamel or the care of his patients, given the responsibilities we had in comparison with those of other bodies referred to previously. In theory we might have heard of complaints or concerns through contact with NHS Tayside personnel on other matters, but we can find no evidence that any concern or complaint was raised with us either directly or indirectly. As already mentioned, to the best of my own knowledge and recollection, at no time was I or my organisation advised of any complaints or concerns about the work of Mr Eljamel in the course of any interactions we had with NHS Tayside since I joined HIS.

12.3. A range of developments since the relevant period have increased the likelihood that HIS may become aware of concerns about professional practice, particularly where these raise issues about systems of governance relating to the quality and safety of care provided. These include:

- the introduction of the NCAL line and the designation of HIS as a prescribed person under PIDA and the establishment of the Responding to Concerns process referred to in response to question 11 above, paragraph 11.6. This process is overseen by a senior-level oversight group which is responsible for reviewing all concerns, whether they arise through whistleblowing or other channels, and determining whether further investigation or intervention is required. This governance structure provides assurance that issues are addressed promptly, transparently, and in a way that supports both organisational learning and the protection of patients and staff. In addition, the process aligns with national Whistleblowing Standards, reinforcing a culture of openness and accountability across health services;
- greater awareness more generally of the importance of whistleblowing and support for this in NHS Scotland including the introduction of the Whistleblowing Standards and establishment of the Independent National Whistleblowing Officer;
- the establishment of the SIHCG and SHCIN referred to in response to question 11 above (paragraphs 11.18 to 11.29), including strengthened relationships and communication between the national bodies involved.

<u>Regulation of Independent Healthcare</u>

12.4. As outlined in response to question 3 above (paragraph 3.2), HIS was established in 2011 with functions which included the regulation of independent healthcare, which was a function transferred to HIS from the Care Commission. The Care Commission is the predecessor body to the Care Inspectorate.

12.5. The regulation of independent healthcare services is made up of five key statutory functions, these are:

- Registration
- Inspection
- Complaints
- Enforcement (registered services), and
- Notifications.

12.6. Through media coverage during 2025, HIS understands that Mr Eljamel may have had practising privileges in Fernbrae Hospital in Dundee during the relevant period. The regulation of Fernbrae hospital transferred to HIS in 2011 from the Care Commission, as an existing service provided by BMI Healthcare (now Circle Healthcare). Circle Healthcare closed the service, and the registration was cancelled on 2 September 2019. There are no records of any complaints made to HIS as the regulator about the service while it was registered with HIS and no matters specifically concerning Mr Eljamel were otherwise brought to our attention in respect of the regulation of independent healthcare services.

12.7. While the service was registered, it was inspected in:

- November 2013 [HIS-00020];
- June 2014 [HIS-00021];
- February 2016; and
- December 2018 [HIS – 00046].

12.8. We have shared the information we still have available. The retention polices that we have in place which apply to our SharePoint site means that the inspection report for 2016 is unfortunately no longer available to us. However, while searching, we took the extra step to review recorded activities and email archives held by colleagues and were able to recover the inspection reports for November 2013, June 2014 and December 2018 which have been provided to the Inquiry.

12.9. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, and this must be in line with the above regulations. HIS expects that providers should be able to demonstrate that their practising privileges policy and procedures are unambiguous in terms of the:

- types of health or care professions who can be engaged in this manner; and
- scope of the practising privileges with respect to an individual application where other forms of agreement are required e.g. other staff that may work with consultants from time to time.

In this respect we refer the Inquiry to the Association of Independent Healthcare Organisations own document 'Practising Privileges Principles' [HIS–00044] produced in 2016 and which still represents current good practice.

12.10. In addition, providers should be able to demonstrate that their practising privileges policy and procedures are:

- developed within the organisational governance framework or quality system and against the context of the requirements of the relevant regulators;
- implemented and managed within the operational governance framework and against the context of good practice human resource policy; and
- monitored, reviewed, and revised within the professional governance framework and against the context of person-centred safe and effective care.

12.11. From records available to us now, within our time as regulator, we have no indication there has been any issue with the granting of practicing privileges to Fernbrae Hospital in Dundee.

13. Please set out a broad chronology of the involvement of HIS or its predecessor bodies with or their knowledge of the professional practice of Mr Eljamel, including: (a) The nature and timing of any intimation to them of matters relating to the professional practice of Mr Eljamel or any other matter falling within the ambit of the Inquiry's Terms of Reference or provisional List of Issues; (b) The nature and timing of any meetings attended by or correspondence involving any representatives of HIS or its predecessor bodies relating to the professional

practice of Mr Eljamel or any other matters falling within the ambit of the Inquiry's Terms of Reference or provisional List of Issues; (c) The process leading to any appointment of Mr Eljamel to any roles within NHS Tayside covered by ToR 1; (d) Any of the investigations relating to Mr Eljamel or systems relating to his professional practice in NHS Tayside covered by ToR 12; (e) The document management systems within NHS Tayside relating to the professional practice of Mr Eljamel over the relevant period or subsequently (as covered by ToR 14); or (f) Any action or decisions taken by or involving HIS or its predecessor bodies relating to the professional practice of Mr Eljamel or any other matter falling within the ambit of the Inquiry's Terms of Reference or provisional List of Issues, including the reasons for any such action or decisions. In setting out the chronology requested under question we above, please identify any key individuals within HIS or its predecessor bodies involved in any of the listed matters and the nature of their involvement.

13.1. Having searched our records as described in Part E below, we have found no evidence that HIS was notified about the actions of Mr Eljamel and NHS Tayside during the relevant period. The Scottish Government did approach HIS in 2023 when it was considering instructing further work in relation to Mr Eljamel, including clinical review of individual cases, but this was not pursued by Scottish Government with HIS [HIS– 0039] and [HIS-00040]. As stated previously, I am not aware of any concerns being raised with HIS by any other potential route.

14. To what extent could HIS or its predecessor bodies have become involved in matters the professional practice of Mr Eljamel? What actions could any such bodies have taken in terms of their legal and regulatory responsibilities?

14.1. As HIS is not the professional regulator of doctors, it would have been beyond the scope of the organisation's functions to become involved in Mr Eljamel's professional practice. Matters of concern regarding his fitness to practice would have been a matter for the General Medical Council. If there were broader matters of serious concern related to the safety of care, either NHS Tayside or the General Medical Council could potentially have brought these to the attention of HIS, but we hold no evidence to suggest this happened. As mentioned previously, had we been informed or heard about any matters of concern, we would not have ignored them but taken steps to raise with the relevant bodies, in the first instance namely the employing Health Board.

Part D – Complaints and Concerns

15. To what extent, on what grounds and by whom could complaints or concerns about the professional practice of a consultant neurosurgeon, such as Mr Eljamel, have been raised with HIS or its predecessor bodies over the relevant period or subsequently? In particular: (a) What action or censure was HIS empowered to take with regard to such issues? (b) Were any such systems of raising complaints or concerns available to members of the public, including patients? (c) What whistleblowing opportunities/ mechanisms did HIS provide for other surgeons regarding the performance or conduct of neurosurgical consultants, like Mr Eljamel?

15.1. The responses to questions 11 and 12 above set out the role of HIS and how this has evolved over time in respect of the Public Interest Disclosure Act and Responding to Concerns, the Sharing Intelligence for Health and Care Group and the Sharing Health and Care Intelligence Network and the Regulation of Independent Healthcare services.

15.2. HIS was designated as a prescribed body under the Public Interest Disclosure Act effective from October 2014. Since then, a small number of concerns relating to or including the practice of individual clinicians, rather than wider safety and quality issues which are typically raised, have been shared with HIS through this route. These were assessed through the process in place at the relevant time, recognising that this assessment process has evolved over time. Actions taken by HIS depended on the circumstances in each case, for example, signposting the individual raising concerns to local whistleblowing processes, raising concerns with the relevant NHS board, and seeking assurance regarding the board's response.

15.3. NHS Boards are required to have arrangements in place for handling and responding to feedback, comments, concerns, and complaints about NHS services in line with the Patient Rights (Scotland) Act 2011 and the NHS Complaint Handling Procedure.

15.4. There is a national policy in NHS Scotland underpinned by legislation to support and protect individuals in raising concerns about patient safety. Scottish Government requires each NHS board to designate a whistleblowing champion who

has responsibility to seek assurance that the systems and processes within that board are working effectively and crucially that staff are actively encouraged and supported to raise any concerns about patient safety. The Independent National Whistleblowing Officer (INWO) in Scotland can review any concern that has been raised through the National Whistleblowing Standards.

16. Were any such complaints or concerns raised? If so, (a) By whom? (b) When? (c) What was the nature of the complaint or concern? (d) What process or investigation took place? (e) What was the outcome/ how were the complaints or concerns resolved?

16.1. Having searched our records as described in Part E below, we have found no evidence that HIS was notified about the actions of Mr Eljamel and/or NHS Tayside during the relevant period.

Part E – documents

17. Please set out the broad locations of where documents thought to be relevant to the requests made in this rule 8 request were stored, including hard copy or electronic systems, and the identity of the party who or which controls or administers such systems.

Physical publications and records

17.1. HIS has an archive collection of print publications within its Glasgow office base. The collection includes HIS, NHS QIS and some predecessor organisation publications. It is not a comprehensive archive of predecessor organisation content or an entire back catalogue of HIS publications in physical format.

17.2. HIS ceased to produce printed publications in 2011. As a result of the move to digital only publishing, arrangements were put in place for copies of online publications to be deposited with the National Library of Scotland and the British Library under legal deposit.

17.3. Healthcare Improvement Scotland website publications have been deposited with the National Library of Scotland (NLS) and the British Library (BL) as of 2011.

17.4. The physical collection is managed by the Research and Information Service and the Information Governance Team.

17.5. HIS does not store physical business records relating to our programmes of work or governance of the organisation at any location.

Digital Information

17.6. HIS operates several internal digital information systems which underpin the delivery of key services provided by HIS and an internal shared drive environment containing live and archived files. All information relating to the regulation of independent healthcare in stored in the MS Dynamics customer relationship database. There is a MS SharePoint site associated with the Dynamics database where associated documents are stored. The system is controlled by HIS. Given the nature of the Rule 8 requests, the MS system for the regulation of independent healthcare and the shared drive environment holding live and archive files have all been included as in scope for the Inquiry. We do not believe we hold anything in any of our other systems that fall within the Inquiry's Terms of Reference.

17.7. Healthcare Improvement Scotland operates a number of websites with the main corporate site hosting information relating to improving care, clinical guidance, and assurance activities. This site underwent redevelopment in 2024. An archive of the previous website contains information relating to the programmes of HIS from 2010 onwards and was included as a relevant source of information in relation to the Inquiry.

17.8. The technical provision, access control and maintenance of the shared drive environment is the responsibility of the ICT team within the Digital Services Group led by the Head of Digital Services.

17.9. The Information Governance Team, led by the Information Governance Team Lead, are responsible for policy and procedure regarding the management of the shared drive content in accordance with records management legislation. HIS operates a system of information asset owners and information asset administrators who are responsible for the application of the records management policies and procedures to the information generated during business activities for which they are responsible.

17.10. Assurance on the status of our controls is provided by the Information Governance and Information Communication and Technology Team to the Information Governance and Security Group chaired by the organisations' Senior Information Risk Owner.

17.11. The HIS website and archive are managed by the Communications Team led by the Head of Communications.

18. As far as the searches for documents undertaken by HIS as per the request made in Appendix C below are concerned, as regards of the categories of documents which has been requested: (a) Please indicate what searches for documents have been undertaken for each category, including where such searches were undertaken and why these searches were thought to be comprehensive as regards the documents sought in each category, including details of search terms used on electronic systems of document storage); (b) If there are significant classes of documents which were thought to have existed at some point relevant to a search category which no longer exist or are no longer held by, on behalf of or under the control of HIS, please identify what these are; (c) If there are significant classes of documents which were thought to have existed at some point relevant to a search category which no longer exist or are no longer held by, on behalf of or under the control of HIS, please identify broadly what has happened to them (including whether they have been lost or destroyed and, if so, when and why); and (d) If there are significant classes of documents which were thought to have existed at some point relevant to a search category which no longer exist or are no longer held by, on behalf of or under the control of HIS and HIS is aware of these being held by or on behalf of another party, please indicate the nature of these documents and by whom HIS believes them to be held.

(a) Please indicate what searches for documents have been undertaken for each category, including where such searches were undertaken and why these searches were thought to be comprehensive as regards the documents sought in each category, including details of search terms used on electronic systems of document storage);

Physical publications

18.1. The print archive collection inventory was reviewed and the physical storage manually investigated to retrieve items thought to be of relevance to the scope of the Inquiry. As mentioned earlier, the titles of these publications were searched for potential relevance. We are unfortunately not in a position to comment on the content of any publication produced by NHS QIS, CSBS, HTBS and any questions on these documents should be directed to the authors of the documents. Items thought to be of potential interest to the Inquiry are listed for the Inquiry's information [HIS-00022]. The full inventory of publications held in the physical archive can also be provided if required.

18.2. The catalogues of the National Library of Scotland (NLS) and National Records of Scotland (NRS) were searched for items deposited by NHS QIS and HIS using relevant keywords. We conducted this search in the same way as all of our searches, using key words set out in paragraph 18.6.

18.3. Our list of holdings deposited at the British Library was also reviewed for this purpose. Both print items and deposited pdf publications were identified through these searches. We conducted this search in the same way as all of our searches, using the key words set out in paragraph 18.6.

18.4. A search was also undertaken within the NRS catalogue for documents relating to the predecessor bodies to NHS QIS. From these results, it is clear that the Board Papers of the Clinical Standards Board for Scotland were deposited with NRS. These are not our documents, we do not hold them, and therefore we are not in a position to comment on them. We have highlighted their existence to help the Inquiry in its own investigations in relation to the work of the CSBS.

Digital Information

18.5. Searches were conducted the shared drive environment which is structured into live and archived data. The drives were searched using Treesize software which interrogates folder paths, file names, and file content for keywords. Searches were conducted in December 2024 and November 2025.

18.6. Keywords used in all of our searches are listed below. Date or file type restriction was not applied.

- NHS Tayside AND adverse events;
- NHS Tayside and reviews;
- NHS Tayside and RTC;
- Ninewells and neur*;
- Dr Sam Eljamel OR Eljamel;
- (Neurosurg* OR neurology) AND (standards OR guidelines);
- Medical revalidation; and
- Fernbrae.

18.7. The searches generated 219 items for further review out of a total of 15,522 items. At review stage the date limit of 1995-2015 was applied and all of these 219 items were reviewed. We undertook a further search of our records from 2015 to the present date, and did not find anything of relevance to the Inquiry.

18.8. The archived data is structured into two areas. The main archive drive (R drive) contains documents and business records structured as per the corporate file plan [HIS-00023] and managed in line with the Retention and Disposal Policy [HIS-00024] and a second archive area (K drive) containing documents originating from prior to the shared drive restructure in 2016. As this is the oldest of the archive drives a manual review of the content was also undertaken during which it was identified that over-retention of data has occurred and some documents relating to the NHS QIS predecessor bodies were located however these are not of relevance to the Inquiry.

18.9. The live drive environment contains the last two financial years' worth of data and although theoretically out of scope of the request was included in our searches. This was due to the manual nature of the environment within which we manage our documents and the possibility that relevant historical files could have been manually moved to a live current location. Nothing of relevance was identified.

18.10. In relation to the regulation of independent healthcare, the records for Fernbrae Hospital were retrieved from the relevant database, and the associated records were manually reviewed for relevant information. Under the main record for the service, all associated records are available. This includes

inspection records, as well as notifications and complaints about the service. The SharePoint location for the service was also reviewed to locate relevant, available documentation. We used the same key word searches as set out in paragraph 18.6.

18.11. The HIS email system was not searched. The rationale being that the date range of interest to the Inquiry is prior to our migration to the current email system which occurred in 2020. As part of the migration plan a cleansing campaign was undertaken to prepare the data for the migration to the new system. Emails prior to 2020 that were saved into project or administrative folders on the drives are available. The searches across our drives were not limited by file type so emails kept as HIS official records pre 2020 were retrieved and reviewed for relevance. We used the same key word searches as set out in paragraph 18.6. Also, where individual staff members have retained emails in their account it is theoretically possible that pre 2020 emails may still reside within an individual's user account. However, at this stage we have not asked individual staff to conduct their own email searches.

18.12. Our current email policy [HIS-00025] requires staff to store emails which are business records within the relevant business folder in the shared drive environment following a standard document naming and version control procedure. Our email policy also requires staff to not routinely archive email. The shared drive searches located all file types that are routinely processed including email, and it was not thought necessary to undertake any other form of search given the low likelihood that email within the date range of interest is residing within current individual accounts. The first HIS email policy is provided for information [HIS-00026].

18.13. Informal communications and individual note taking methods for individual purposes such as text messaging and the use of notebooks do not have an entry in the HIS retention schedule [HIS-00027]. These record types are also not present in previous HIS retention schedules and as such they were not considered in scope of the request [HIS-00028].

18.14. HIS operates several websites. A core website hosting information and publications relating to our regulatory and assurance, improvement, and clinical guidance roles, the HIS Engage site relating to our Community Engagement Role, the Scottish Medicines Consortium, and the Scottish Health Technologies Group. The hosting

and design of this site changed in February 2024. As part of the website change only select content was migrated to the new website to reflect current work streams. An archive website was created of HIS content ranging from 2010-2024. The archive site has been reviewed for the purposes of the Inquiry, using the same key word searches set out in paragraph 18.6.

18.15. HIS holds a PDF library of NHS QIS published outputs although it is not known if this is an entire archive of everything NHS QIS published. The titles of these publications have been reviewed for relevance to the Inquiry as we are not in a position to comment on their contents.

18.16. We believe a comprehensive search has been undertaken across our information assets.

(b) If there are significant classes of documents which were thought to have existed at some point relevant to a search category which no longer exist or are no longer held by, on behalf of or under the control of HIS, please identify what these are;

18.17. HIS does not hold details of the transition of the Clinical Standards Board for Scotland or other predecessor bodies into NHS QIS. The catalogue of the National Records of Scotland (NRS) details CSBS Board Papers and the National Library of Scotland lists CSBS publications as being held in archive. It is not known when these papers were transferred or if they are a complete collection and whether details of the transition are contained within the documentation. Publications and Board papers from the other predecessor bodies can also be accessed via NRS. We are unable to comment on the content of any of these documents,

18.18. We are not aware of significant classes of document related to NHS QIS or HIS that are thought to have existed, and which are no longer available and of relevance to the Inquiry. We have identified and located relevant publications and Board Papers held within our environment or deposited within national archives and libraries.

(c) If there are significant classes of documents which were thought to have existed at some point relevant to a search category which no longer exist or are no longer held by, on behalf of or under the control of HIS, please identify broadly what has happened to them (including whether they have been lost or destroyed and, if so, when and why);

18.19. We are not aware of significant classes of document related to NHS QIS or HIS that are thought to have existed, and which are no longer available and of relevance to the Inquiry.

18.20. We thought it helpful to outline the history of records management within HIS and NHS QIS to support our response to this question.

18.21. Some sections of the Public Records (Scotland) Act 2011 (PRSA) came into force on 1 January 2013 and some on 24 February 2012. At the point of dissolution of NHS QIS in 2011 only one records management related policy was in place, the Document Naming and Version Control Policy introduced in 2010 [HIS-00029]. At that time, the Scottish Government Code of Practice for Records Management 2010 was also made available to staff via the Intranet [HIS-00030].

18.22. It is not known what records management procedure and guidance was in place during the early days of NHS QIS. Nor do we know what existed during the tenure of the CSBS.

18.23. We do hold information which shows that records management activity commenced in 2009. This activity included a rationalisation of multiple shared drives and introduction of an organisation wide folder structure and document naming convention. There is no recorded information regarding document disposal that took place at this time, however volume reduction was part of the rationalisation activity as documented in a records management conclusion report produced as part of the governance of the dissolution of NHS QIS. The conclusion report [HIS–00045] documents the approach to the management of records as of 2011 and although not stated it is inferred that the new structure introduced through the rationalisation exercise housed all relevant records transitioning from NHS QIS into HIS.

18.24. All documents and records have then progressed to being managed in line with policies developed and introduced in accordance with the Public Records (Scotland) Act 2011 (PRSA) within HIS.

18.25. In the interval from the founding of HIS to the coming into force of the PRSA in 2013, a Records Management Policy [HIS-00031] and the previously referenced Retention and Disposal Policy [HIS-00024] and Retention Schedule [HIS-00027]

were introduced to HIS. The retention period for records associated with main delivery plan objectives was at that time 6 years.

18.26. In 2017 an exercise to restructure and cleanse the shared drive environment in accordance with the retention schedule was undertaken. The resulting file plan demonstrating the functions and activities of HIS is provided in the corporate file plan, in paragraph 18.8 [HIS-00023]. Given the 6-year retention period any project records from the predecessor bodies that were carried over into HIS functions and activities would have been in scope for disposal during this exercise. Disposal of records is evidenced in our disposal registers which date from 2017 onwards of which an example is provided [HIS-00032]. Our current email retention schedule is already referenced above [HIS-00025].

18.27. We are aware that application of the policies is inconsistent and that over-retention of documents and records does occur across the organisation. This knowledge has been reinforced through the searches and manual reviewing of folders undertaken for the purpose of the Inquiry, however no significant documents of relevance to the Inquiry have been identified within documentation which has been over-retained.

(d) If there are significant classes of documents which were thought to have existed at some point relevant to a search category which no longer exist or are no longer held by, on behalf of or under the control of HIS and HIS is aware of these being held by or on behalf of another party, please indicate the nature of these documents and by whom HIS believes them to be held.

18.28. The Board papers related to the NHS QIS predecessor bodies, which may contain relevant information, are held by National Records of Scotland.

19. Please certify that the documents which have been produced in response to this rule 8 request are, to the best of HIS's knowledge and belief, all documents held by HIS, on its behalf or under its control.

19.1. I can certify that all documents produced in response to this Rule 8 request are, to the best of my knowledge and belief, are all documents held by HIS or under our control, or are available in the public domain.

Part F – conclusions

20. Please state what the HIS considers the key challenges were, its understanding of the reason for those challenges, what went well and what did not (either as was apparent at the time or in hindsight), and whether HIS or its predecessor bodies identified (at the time or subsequently) things that could or should have been done differently in the way that systems which existed to promote the best interests the former patients of Mr Eljamel over the relevant period or subsequently.

20.1. Based on the current information that is available, HIS is not able to fully respond to this question at present. As HIS had no involvement with Mr Eljamel's activities, we are unable to comment or compare the circumstances of that time with any alternative approaches. However, we await to hear the evidence that will emerge from the Inquiry. HIS wishes to contribute to the Inquiry in as full a way as it can and wish to understand the specific issues that related to Mr Eljamel and his clinical practice and the lessons which can be learned and what improvements can be made for both the oversight of the clinical practice of doctors and the system more generally.

21. What lessons, if any, has HIS or its predecessor bodies learned from its/ their involvement in the systems which existed to promote the best interests of the former patients of Mr Eljamel over the relevant period.

21.1. As stated in response to question 20 above, although not involved in the oversight of Mr Eljamel's clinical practice, HIS wishes to contribute to the public inquiry in as full as way it can and will wish to understand the specific issues that related to Mr Eljamel and his clinical practice and the lessons for both the oversight of the clinical practice of doctors and the system more generally.

22. Please refer to anything else HIS or its predecessor bodies considers/ consider may be of substantial interest to the Inquiry in relation to the systems which existed to promote the best interests of the former patients of Mr Eljamel over the relevant period. In addition, please identify any key areas/ systems/ practices which HIS or its predecessor bodies considers/ consider worked well, and any key areas in which you/ they consider there were issues, obstacles or missed opportunities.

22.1. Over the past decade, HIS has been working to integrate its functions into a more cohesive approach to supporting improvement. In doing so we recognise that there is not one answer to improving the safety and quality of care but a range of interventions – consistent with a quality management system – that balances different approaches across evidence, external assurance, and improvement support. HIS can ensure an integrated approach which improves effectiveness, co-ordination, and impact.

22.2. As outlined previously HIS has developed a structured approach to external assurance, including inspections [HIS–00012]. These inspections are underpinned by nationally agreed standards and detailed guidance, ensuring clarity of expectations and consistency of assessment. Each inspection now includes explicit requirements and actionable recommendations, providing a transparent framework for improvement. Furthermore, external reviews are led by senior, highly experienced healthcare professionals drawn from across the UK, bringing independent expertise and fresh perspectives. This evolution has significantly strengthened the objectivity, robustness, and credibility of our assurance processes, reinforcing public confidence and supporting continuous improvement across the health system.

22.3. HIS has developed an early warning framework through the Sharing Health and Care Intelligence Network, [HIS–00008] designed to identify signals that may indicate emerging concerns within individual NHS Boards. These signals focus on critical areas such as leadership, organisational culture, and governance, recognising that weaknesses in these domains often precede more significant failures in care quality and safety. The framework is informed by lessons drawn from past challenges across the UK health system, where systemic issues—rather than isolated incidents—have contributed to serious shortcomings. By proactively monitoring these indicators, the framework aims to support timely intervention, collaborative problem-solving, and the prevention of harm before it escalates.

22.4. Since 2013, HIS has been progressively developing and refining the approach to the identification and learning from adverse events [HIS-00033]. An adverse events review was carried out at NHS Tayside in July 2013, the report on which was published in September 2013 [HIS-00034].

22.5. The latest iteration of the Framework, published in 2025, introduced more robust requirements for NHS Boards [HIS-00033]. This includes monthly reporting of quantitative data to demonstrate performance against key elements of the Framework, as well as quarterly reporting on broader progress in meeting its expectations. This approach aims to ensure that improvement is not only measured but actively monitored and supported at a system level.

22.6. A central principle of this National Framework for Adverse Events —complementing the Duty of Candour legislation — is the need to embed a cultural shift towards openness, transparency, and learning. This is not simply a procedural change; it represents a fundamental transformation in how organisations respond to harm and risk. Achieving this requires a commitment to honesty in communication, timely disclosure to patients and families, and a willingness to share lessons learned across teams and organisations. Ultimately, the goal is to create an environment where staff feel safe to report, leaders model accountability, and the system prioritises continuous improvement.

22.7. Over the past decade, HIS has significantly strengthened its authority and capacity to escalate concerns when serious risks to patient safety, governance, or leadership arise. This escalation can extend from initial engagement with NHS Boards to formal notification of the Scottish Government and, where necessary, direct communication with the Cabinet Secretary for Health and Social Care. The Operating Framework (paragraph 10.5) between Healthcare Improvement Scotland and the Scottish Government (see response to question 10(b) above) provides the foundation for this relationship [HIS-00007]. It sets out both the principles of collaboration and the specific mechanisms for escalation, ensuring clarity and accountability. Importantly, the Operating Framework reinforces the independence of Healthcare Improvement Scotland, while detailing the range of actions available, up to and including the closure of wards to new admissions where patient safety cannot be assured.

22.8. Since 2020, Healthcare Improvement Scotland has also embedded the Scottish Patient Safety Programme's *Essentials of Safe Care* framework [HIS–00013] across the health system. This framework reflects the critical role of communication, culture, and leadership in creating environments where patients and staff are safe, respected, and supported. It emphasises that technical processes alone cannot

deliver safety; rather, it is the combination of strong leadership, open dialogue, and a culture of continuous learning that underpins sustainable improvement.

22.9. It is also important acknowledge, from public inquiries that have concluded and reported, that matters of concern in relation to patient safety, reflect not only individual behaviours but a consequence of issues such as insufficient governance, systemic working conditions or cultures that permit and support a lack of safety and appropriateness of practice, and also the conditions which do not encourage individuals to speak up or to raise concerns.

23. Please set out what, if anything, HIS or its predecessor bodies considers/ consider can be done to improve systems which existed to promote the best interests the former patients of Mr Eljamel over the relevant period for the benefit of future patients like the former patients of Mr Eljamel in which HIS or its predecessor bodies played a part/ of which it has knowledge.

23.1. The interconnected nature of the healthcare system reinforces the critical importance of open and proactive sharing of intelligence and knowledge between agencies. Issues that appear to relate solely to the clinical practice of an individual or the performance of a frontline team often have deeper roots. They may signal underlying challenges in organisational culture, leadership behaviours, or governance structures. Recognising these connections is important because what may seem like an isolated clinical concern can be an indicator of systemic risk.

23.2. This emphasises the need for NHS bodies and partner organisations to ensure timely and transparent communication of safety concerns with HIS. Early sharing of information enables a coordinated response, supports learning across the system, and helps prevent escalation into more serious failures. By fostering a culture of openness and collaboration, the health system can move beyond reactive interventions and foster continuous improvement.

Statement of Truth

I believe that the facts stated in this written statement are true.

Signed 

Date 16 March 2026