

Review of Unresolved and Outstanding Concerns regarding Professor Eljamel, Former Consultant Neurosurgeon at NHS Tayside.

Scottish Government, May 2022

OFFICIAL SENSITIVE

Summary

This report was commissioned by Jeane Freeman formerly Cabinet Secretary for Health and Sport - to look into the unresolved questions and concerns of Mr. Patrick Kelly and Ms. Julie Rose in respect of the care provided to them by Professor Eljamel, former Consultant Neurosurgeon at NHS Tayside.

Terms of reference were agreed with Ms. Rose and Mr. Kelly for the review and for the associated casenote reviews carried out by two independent neurosurgeons from outside of NHS Scotland.

Information held by Scottish Government, provided by Ms. Rose and Mr. Kelly, NHS Tayside and the independent neurosurgeons was considered.

The review has focused on Professor Eljamel's accountability. It has also reviewed the accountability of NHS Tayside. This has focused on their legal duty of quality and implementation of guidance on clinical governance.

Mr. Kelly and Ms. Rose were kept informed and were involved throughout the review process. They were provided with draft versions of the independent case note review and of this report and invited to comment on factual accuracy.

This report makes key observations and recommends actions to be taken.

The Scottish Government contracted two independent neurosurgeons from NHS England to look at the casenotes of Mr. Kelly and Ms. Rose.

Mr. Kelly and Ms. Rose met with the neurosurgeons and also provided feedback on drafts of the reports submitted. These comments have been considered in preparing this report.

Mr Tolias and Miss Gilkes, the Independent Consultant Neurosurgeons, concluded that Professor Eljamel did not act in accordance with the standards they would have expected in respect of consent, counselling and providing information.

They were concerned about how supervision of Professor Eljamel was implemented.

Miss Gilkes' opinion was that Ms. Rose's care experience was negatively affected by the probity and practice matters identified in the review carried out by the Royal College of Surgeons of England. She also stated that Professor Eljamel 'cut corners' and did not act with the honesty and integrity required by the General Medical Council.

She said that she believed that all of Professor Eljamel's patients should have been subject to supervision and review.

Mr. Kelly and Ms. Rose have said that they do not agree with some of the comments expressed by the independent surgeons.

OFFICIAL SENSITIVE

Before this review, NHS Tayside had reviewed many of the issues and concerns reflected in Mr. Kelly and Ms. Rose's unanswered questions.

This report has found that the responses, communication and support provided by NHS Tayside to Mr. Kelly and Ms. Rose could have been improved during and after the various reviews undertaken by NHS Tayside.

This review found that there was no requirement for NHS Tayside to report the events relating to Professor Eljamel's practice to the Health and Safety Executive.

NHS Tayside recognised before that they needed to improve some elements of their clinical governance processes when responding to concerns about Professor Eljamel.

The decision to supervise Professor Eljamel did not appear to take account of wider risks to all of Professor Eljamel's patients and was not effectively implemented.

NHS Tayside did not fully discharge their accountability in providing timely, open and transparent responses to questions, and did not fully address the 'what' and 'why' aspects of these unanswered questions.

Further improvements are required on the way in which the NHS Tayside Board is assured on the effective implementation of changes and improvements.

In 2018, the Scottish Government asked NHS Tayside a series of questions regarding the number of complaints they received about Professor Eljamel.

Following this, the Cabinet Secretary wrote to all NHS Boards in Scotland and received assurances that any required changes were being implemented by NHS Boards, including NHS Tayside.

Following this, the Scottish Government also asked NHS Education for Scotland and Healthcare Improvement Scotland to work on support to improve openness and learning across NHS Boards.

This report recommends that NHS Tayside:

- make sure there are effective ways of providing feedback when people have ongoing concerns like Ms. Rose and Mr. Kelly
- review the way that they measure the effectiveness of the actions taken when there are reviews like the ones undertaken by the Royal College of Surgeons and external clinicians.
- outline the way that they identify and consider people who return to theatre within 30 days.
- consider whether their appraisal processes are as robust as they need to be.

OFFICIAL SENSITIVE

- ensure that Mr. Kelly and Ms. Rose receive care and support for the ongoing impact and distress of their experiences. This should recognise the potential for positive impact through this dialogue.

In addition to the above it is recommended that:

Mr. Kelly and Ms. Rose should be offered a session with the Chair and Chief Executive of NHS Tayside to discuss their experiences, this report and how further change, learning and improvement can be put in place.

Mr. Kelly's unanswered questions about why a Consultant Urologist was involved in his surgery and what happened on that day should be responded to.

Ms. Rose should receive an apology about all of Professor Eljamel's patients not being subject to review and supervision.

The Scottish Government should improve the way it arranges the commission of independent clinical reviews.

The Scottish Government should make policy teams aware of the recommended actions of this review.

NHS Tayside's actions in response to this report should form part of the performance and review cycle that NHS Boards follow. This should include an action plan outlining how the recommended actions will be effectively implemented.

The consultant neurosurgeons recommended that NHS Scotland should:

- establish a regional or national pathway for orbital tumours that encourages shared experience and learning.
- develop guidelines for NHS Boards for Consultant Supervision.
- consider joining the National Neurosurgical Audit Programme.

This report concludes that NHS Tayside and Scottish Government should consider these recommended actions and provide Mr. Kelly and Ms. Rose with copies of actions plans that include a clear description on how assurance of effective implementation will be measured and reported on.

OFFICIAL SENSITIVE

Review of Unresolved and Outstanding Concerns regarding Professor Eljamel, Former Consultant Neurosurgeon at NHS Tayside.Background

1. The Cabinet Secretary for Health and Sport, Jeane Freeman, asked that a review be commissioned into the unresolved questions and concerns of Mr. Kelly and Ms. Rose in respect of the care provided by Professor Eljamel, Consultant Neurosurgeon and specifically the actions taken by NHS Tayside regarding the investigation and surrounding governance considerations of these investigations and actions arising from them.
2. Mr. Kelly and Ms. Rose then worked with officials to scope and agree Terms of Reference for the overall review process, including the scope of specific Terms of Reference for independent clinical opinion to be provided by Consultant Neurosurgeons practising outside of NHSScotland (see Annex A for Terms of Reference for both elements of this review).

Process

3. Officials engaged with Mr. Kelly and Ms. Rose, with NHS Tayside and the independent neurosurgeons to implement this review and, as part of this, have reviewed all of the information held by Scottish Government, the information provided by Mr. Kelly and Ms. Rose throughout this review (including email correspondence and information held by them personally), and information provided by NHS Tayside when requested.
4. This report has considered the views of the independent consultant neurosurgeons commissioned to review the care provided to Mr. Kelly and Ms. Rose, the actions taken by NHS Tayside and Scottish Government in respect of the concerns raised in respect of Professor Eljamel, and makes recommendations for actions for NHS Tayside and Scottish Government.
5. Throughout this review process officials have kept in regular contact with Mr. Kelly and Ms. Rose who have provided comments, feedback, responses and further information on the nature and impact of their historical and ongoing concerns relating to accountability, transparency, impact and effectiveness of assurance that changes have been effectively implemented.
6. It was agreed that this review would consider Mr. Kelly and Ms. Rose's concerns about the actions of Professor Eljamel on their experience of care, the actions of NHS Tayside (including those relating to engagement with other organisations) and Scottish Government.
7. Mr. Rose and Ms. Kelly were provided with draft versions of the independent case note review and of this report and invited to comment on factual accuracy. NHS Tayside were also invited to provide factual accuracy feedback. These comments were considered by the independent neurosurgeons and officials supporting this

OFFICIAL SENSITIVE

review process. The majority of responses provided to these requests for factual accuracy were clarifying questions in respect of the observations and recommendation made and/or statement of differences of opinion on these or the actions required. In some instances the feedback received understandably expressed distress and frustration on where it was not possible to provide answers on the basis of the information that was available for the review, or because the findings of the review reflected current legislative obligations (particularly those in respect of the HSE).

8. This report outlines key observations arising from the review work and provides recommended actions.
9. In conducting this review process, officials have considered the professional accountability of Professor Eljamel to Mr. Kelly and Ms. Rose, the accountabilities of Executives of NHS Tayside in respect of the statutory duty of quality and the effective implementation of guidance relating to clinical governance.
10. The essence of accountability is answerability; being accountable means having the obligation to answer questions regarding decisions and/or actions. This requires transparency and openness that covers both the 'what' and 'why' of actions taken and their impact.

Independent Casenote Review

11. Scottish Government commissioned two independent neurosurgeons to conduct a review in accordance with the Terms of Reference agreed with Mr. Kelly and Ms. Rose, including a request that the neurosurgeons should not have a connection with NHS Scotland. Mr. Kelly and Ms. Rose were provided with final drafts of these reports to provide factual accuracy feedback to the Consultant Neurosurgeons (Mr Tolias, Consultant Neurosurgeon who reviewed Mr. Kelly's case and Miss Gilkes, who reviewed Ms. Rose's case). They were then provided with the responses of the Consultant Neurosurgeons and have submitted their further commentary and responses to these, which have been considered in formulating this report.
12. This process of commissioning the independent clinical reviews took longer than anticipated due to the need to consider how procurement processes used by Scottish Government could address the specific information governance, insurance and information security requirements in ways that took account of the working practices of the independent clinicians.
13. Through these reviews Mr. Kelly and Ms. Rose have been provided with independent clinical opinion on the issues and concerns relating to their clinical care. These reports have considered and provided responses to the individual questions raised by Mr. Kelly and Ms. Rose at the point at which the scope and Terms of Reference for these reviews were agreed. Mr. Kelly and Ms. Rose both had the opportunity to meet with the independent neurosurgeons and provide comment on drafts of their review reports.

OFFICIAL SENSITIVE

14. Mr. Kelly and Ms. Rose have outlined several areas where they do not agree with the conclusions reached by the independent consultant neurosurgeons. However, both Consultant Neurosurgeons have provided their responses to questions raised by Mr. Kelly and Ms. Rose and have highlighted the organisational systems and processes that appear to have influenced the provision of care and experience of Mr. Kelly and Ms. Rose. Both have also considered changes or improvements in governance and related processes of relevance to the matters they considered. Officials have accepted that both neurosurgeons have conducted the reviews they were commissioned to provide.
15. Mr. Kelly and Ms. Rose have both provided further comments on the independent neurosurgeons responses to their feedback. This has been reviewed and considered by officials. This is outlined in the sections below.

Ms. Rose

16. Ms. Rose has expressed her dissatisfaction with Ms. Gilkes' investigation and report in strong terms, suggesting that Miss Gilkes has made comments influenced by "political and tactical" intention. Ms. Rose's specific concerns are:
 - Miss Gilkes' description of her experience of follow up neurosurgical and ophthalmology care;
 - An opinion has not been provided on whether Professor Eljamel performed her first surgery;
 - Miss Gilkes was not provided with Miss Gillies' report;
 - Miss Gilkes made no further comment on issues covered in her original report through Ms. Rose's follow up questions;
 - The reference to Ms. Rose's complaint is incorrect; and
 - Ms. Rose does not agree with Miss Gilkes' opinion in respect of Dr Smith (a pathologist in the neuropathology department in NHS Lothian).
17. Ms. Rose has also submitted documents from a retired Consultant Neurosurgeon, who expressed concerns in relation to:
 - Clinical governance processes relating to complaints;
 - Monitoring of surgical outcomes;
 - The reliance on surgical outcomes and professional appraisal system on the engagement of individual clinicians;
 - Professor Eljamel's practice in respect of working with junior medical staff;
 - The arrangements and decision-making in respect of the practice and supervision of Professor Eljamel;
 - That nothing was done in response to initial complaints about Professor Eljamel; and
 - That actions proposed by NHS Tayside to improve processes are not clear.

OFFICIAL SENSITIVE

18. Miss Gilkes' comments about follow up care appear to relate to clinical care and did not disagree with distress and diminished experience of care as outlined by Ms. Rose. Miss Gilkes stated "I am confident that he performed her surgery". It is reasonable for Miss Gilkes to have referred back to the content of her report in responding to follow-up questions posed. All of the matters referred to by Mr. Campbell in respect of clinical governance have been reviewed and NHS Tayside described the changes identified as necessary as a result of this. The number of complaints was recorded by NHS Tayside and they confirmed that they did not classify Ms. Rose's communication as a complaint, itself supporting the need for improvements in the clinical governance processes that link Board systems and processes involving complaints, adverse events and concerns relating to professional conduct as part of an improved clinical governance process.

Mr. Kelly

19. Mr. Kelly has expressed his dissatisfaction with Mr. Tolias' investigation and report in strong terms, believing this to be a "smokescreen" and "a load of medical baloney". He believes that there should have been greater focus on investigation of events on the day of his surgery by Professor Eljamel and outlined his beliefs about "conspiratorial silence" and that Eljamel's actions should not "go unpunished".
20. Mr. Kelly also highlighted concerns in respect of the opinion expressed by a Consultant Neurosurgeon instructed as an expert by his solicitors during a case that settled out of court.
21. Mr. Kelly highlighted an error in Mr. Tolias' reference to the content of a letter of 27 September 2006 to his GP from an SHO in Neurosurgery (the addition of the word 'not'). Mr. Tolias was asked to confirm whether he was content for this error to be corrected in his reference to that letter and whether there were any changes to the content of his report that were necessary given this error.
22. Mr Tolias did consider events in respect of the day of surgery and stated that it was "almost impossible to comment based on what I have seen". No information is available beyond that has already been provided to Mr. Kelly in respect of his unresolved questions.
23. Mr. Tolias does not make reference to reliance upon a myelogram report in his report and expresses his opinion which he recognises is different from other clinical opinions expressed at the time and other clinical opinion sought through other review processes, specifically Mr. Kelly's civil claim.
24. Many of the areas of concern and views on Mr. Tolias' opinion are reflective of there being a range of views expressed by clinicians involved in Mr. Kelly's care and a range of processes to review his concerns, including this one. It is not the purpose of this review to seek to resolve differences in clinical opinions expressed at the time or subsequently, though this position does not minimise the ongoing impact of

OFFICIAL SENSITIVE

differences of opinion on Mr. Kelly's understandable need to make sense of the way in which these varying opinions and actions arising from them may have altered his experience of care and/or understanding of the factors that have contributed to his experiences.

25. Mr Tolias outlined that he regarded Mr. Kelly's clinical management to have been sub-optimal; and that there were failures in review, communication and consent processes and their implementation by Professor Eljamel. He described the consent process and senior clinician involvement in Mr. Kelly's care as "woefully substandard" and "one of the main reasons of his continued difficulties and complaints"

Conclusions from Mr Tolias and Ms Gilkes

26. Both Independent Consultant Neurosurgeons were of the view that Professor Eljamel's engagement in the process of pre-operative assessment, patient counselling and consent was not of the standard they would have expected.
27. Both Independent Consultant Neurosurgeons raised concerns about the implementation of supervision arrangements of Professor Eljamel while investigations were ongoing. This was consistent with the outcome of NHS Tayside's earlier internal review on this issue by an Associate Medical Director (though this was not disclosed to Mr. Kelly or Ms. Rose).
28. Ms. Gilkes' view is that the probity and practice issues identified by the Royal College of Surgeons were evident in Ms. Rose's experience of care by Professor Eljamel. She outlined her opinion that Professor Eljamel did not act with honesty and integrity as required by the provision of Good Medical Practice (General Medical Council, 2013).
29. Ms. Gilkes' view was that the scope of the supervision arrangements outlined for Professor Eljamel would have been more effective if patients on Professor Eljamel's waiting list were included in the detailed case based discussions specified as part of the supervision requirements. She also believes that the Royal College of Surgeons review observation that Professor Eljamel 'cut corners' was relevant to Ms. Rose's initial operation by Professor Eljamel.
30. The commission of this review by the Cabinet Secretary was to provide the independent opinion of Consultant Neurosurgeons with no associations to the service or to the NHS in Scotland. Both of these clinicians have provided their opinions independently and, where they have been able to do so, provided feedback to Mr. Kelly and Ms. Rose's feedback on factual accuracy of their draft reports.
31. Mr. Kelly and Ms. Rose have both expressed their distress and disagreement with several elements of this feedback through the submission of further comments. There are several instances where review of Mr. Kelly and Ms. Rose's feedback suggest that the independent neurosurgeons' opinions are at odds with their own, though upon reading each report, there is content where the independent

OFFICIAL SENSITIVE

neurosurgeons agree with the views and concerns continuing to be expressed in further feedback from Mr. Kelly and Ms. Rose.

32. It is outside of the scope of knowledge and expertise of officials co-ordinating this review to comment further on these areas of disagreement on independent expert opinion, though the nature of Mr. Kelly and Ms. Rose's disagreement with both clinicians have been considered in providing this report and the recommended actions. It is outside of the scope of this review to consider actions of organisations such as the General Medical Council.

Actions Taken by NHS Tayside

33. NHS Tayside have undertaken several processes of review in respect of the concerns about Professor Eljamel – including review and response to individual complaints, review of a significant incident involving him, internal reviews by clinical management, commissioning of an external review by the Royal College of Surgeons and a review by a Medical Director from another NHS Board. All of these resulted in identification of actions required to address the issues within each respective review.
34. In an initial internal review by an Associate Medical Director at NHS Tayside, it was suggested that the restrictions recommended in respect of Professor Eljamel's practice were not defined with the precision and definition required.
35. NHS Tayside identified the need for improvements in supporting clinical governance processes, including reporting for oversight and assurance at relevant governance committees; and the development of a clear commissioning process across the whole organisation for all extreme and major adverse events that occur (where all relevant staff are made aware of the event and that a Significant Adverse Event Review (SAER) has been commissioned).
36. NHS Tayside also identified the need to ensure that independent reviewers were assigned to incident reviews, when it was determined that Professor Eljamel was involved in a SAER involving one of his cases, thereby compromising the independence required in such reviews.
37. These improvements in clinical governance processes were reflected in NHS Tayside's Clinical and Care Governance Strategy 2019-2021.¹ This included matters of professional governance.
38. Since this time and following Scottish Government intervention for all NHS Boards, including NHS Tayside, are now required to inform Healthcare Improvement Scotland (HIS) of certain adverse events that have been commissioned for a SAER.
39. NHS Tayside identified the need to improve procedures for the effective recall of patients where patient safety concerns are raised.

¹ [idcplg \(scot.nhs.uk\)](https://www.scot.nhs.uk/idcplg) Clinical and Care Governance Strategy 2019-2021, NHS Tayside

OFFICIAL SENSITIVE

40. NHS Tayside identified the need to ensure that a register of all Consultants who attend Morbidity and Mortality meetings is taken.
41. NHS Tayside recognised the importance of ensuring that when concerns are raised of the nature and number that occurred in relation to the events, complaints, concerns and reviews of the sort initiated by Professor Eljamel's practice that actions are taken to ensure relevant health records are subject to different retention periods than those outlined in national guidance.
42. NHS Tayside identified the need for review of processes supporting the duties of the Responsible Officer to ensure that the necessary communications with the General Medical Council take place in a timely manner.
43. NHS Tayside changed their adverse incident reporting processes to better capture concerns being raised by junior medical staff, supporting by proactive management engagement and dialogue with trainees.
44. This review has considered the scope, nature and outcome of these reviews. Improvement actions arising from reviews by NHS Tayside were not communicated to Mr. Kelly or Ms. Rose, who throughout the time that these were ongoing, continued to make sense of their prior experiences and related concerns and questions, all the while experiencing a growing sense of mistrust and distress. They often have had to invest increasing amounts of their time on seeking information or responses to support this process of making sense of their experiences and contributory factors to events relating to Professor Eljamel's practice and the negative impact on their lives, quality of life, health and wellbeing.
45. It is likely that the adversarial nature of the processes to consider claims of the sort initiated by Mr. Kelly and Ms. Rose through the legal system unhelpfully contributed to patterns and experiences of communication that resulted in several of their questions and concerns regarding contributors to distress not being fully understood, addressed or responded to meaningfully and comprehensively at the time. This served to further increase their distress and sense of mistrust in NHS Tayside's willingness and capacity to engage with them transparently and supportively to minimise the risk of other people having similar experiences to theirs.
46. Communication, engagement and the provision of information to Mr. Kelly and Ms. Rose by NHS Tayside in respect of Professor Eljamel was not always transparent, timely, proportionate or personalised to their individual needs and circumstances.
47. Externally commissioned reviews and reports such as that conducted by Ms. Tracey Gillies should have had formal action plans with measures of effectiveness and implementation defined and then reported through relevant Board clinical governance committees and processes. This would have provided more robust assurance that the changes required had been implemented and could have

OFFICIAL SENSITIVE

supported Mr. Kelly and Ms. Rose to have greater confidence in NHS Tayside's recognition of the areas where improvement support was required.

48. NHS Tayside's duty of quality as outlined in the National Health Service (Scotland) Act 1978 was discharged through their actions in respect of internal reviews and externally commissioned reviews, although the actions taken to consider the implementation and effectiveness of actions could have been improved.
49. NHS Tayside identified that there were several areas in which their clinical governance processes were not as effectively implemented as they could have been. These were identified and actioned internally and outlined in NHS Tayside's response to the Scottish Government in 2018.
50. NHS Tayside acted reasonably in requesting an external review by the Royal College of Surgeons. They also took proportionate action when initial concerns and complaints were raised in relation to Professor Eljamel, though the effectiveness of this process was weakened by the clinical governance process deficiencies some of which were recognised by NHS Tayside. They did not consider involvement of support from Healthcare Improvement Scotland beyond the existing engagement in national programmes of work focused on the issues raised, including the national openness and learning work commissioned following the Scottish Government's engagement event relating to learning following the issues raised by Professor Eljamel's practice.
51. It is likely that several of the outstanding questions and concerns of Mr. Kelly and Ms. Rose could have been responded to more appropriately if the improvements in the quality of review, investigation and supportive engagement with them had been approached differently by NHS Tayside – in particular when concerns, complaints and unresolved questions were raised on several occasions.
52. The current provisions and requirements of legislation and associated frameworks do not require reporting of complaints or individual staff conduct and competence concerns of the sort implicated by Professor Eljamel's actions to be reported to the Health and Safety Executive². This is an issue that has been raised several times during the course of this review.

Actions Taken by Scottish Government

53. In 2018, the Scottish Government asked NHS Tayside for responses to questions in respect of the number of complaints received about Professor Eljamel, the outcome of these, the nature of the response and apology provided to Mr. Kelly and what the learning was in terms of the Board's review of relevant governance procedures and what evidence was available in support of this. This included a review of the way in which 54 complaints received about Professor Eljamel were handled.

² [Who regulates health care \(hse.gov.uk\)](https://www.hse.gov.uk/who-regulates-health-care/) outlines the requirements for the NHS in respect of reporting to the Health and Safety Executive.

OFFICIAL SENSITIVE

54. Following review by officials and further concerns expressed at the time, the Cabinet Secretary for Health and Sport (Ms. Freeman) wrote to all NHS Board Chairs and Chief Executives to seek assurances that the issues raised by consideration of the events in NHS Tayside were adequately addressed within existing Board Governance and Assurance processes. This included several of the areas of ongoing concern and unresolved questions of Mr. Kelly and Ms. Rose.

NHS Complaints

- Mechanisms for the Board to detect and respond to clusters of complaints about the same clinician – with details of the process and timescales for this.
- What arrangements are in place for ensuring timely decision making when the safety of practice of a Consultant is raising concern.

Surgical Safety and M&M Reviews

- Ensuring that there is reliable delivery of process for pre-operative marking.
- Monitoring workloads, surgical list length and appropriately equipped theatres.
- Processes to support clinicians in presenting cases and have time allocated to attend Morbidity & Mortality Reviews.
- Arrangements for reviewing the effectiveness of on-call rotas.

Supervision of Junior Medical Staff

- Consultant oversight supervision of junior medical staff.

Openness and Transparency

- A description of the processes in place to encourage open reporting and discussion of behaviours not consistent with NHSScotland values.
- How quality of outcomes is monitored and any deficiencies reviewed and necessary action taken.

55. A meeting was held with senior Scottish Government staff and senior representatives of all NHS Boards to discuss the specific actions required to support further improvements based on learning from best practice that is reflected in arrangements elsewhere. This followed a letter from the Cabinet Secretary to all NHS Boards setting out the requirement to share good practice to ensure that Boards learn from each other.

56. This event took place on 4 December 2018 and was facilitated by NHS Education for Scotland.

57. The Scottish Government subsequently commissioned work by NHS Education for Scotland and HIS on openness and learning, including improvements required in

OFFICIAL SENSITIVE

systems and processes of relevance to situations such as those being experienced by Mr. Kelly and Ms. Rose.

Conclusions of Review of Actions Taken

58. The clinical governance processes and procedures in place when concerns and complaints were being raised about Professor Eljamel's practice were not sufficiently robust, meaning that clinical leadership for clinical governance of the service was not aware that concerns and processes were not effective in identifying and addressing signs that indicated possible risks to the safety of Professor Eljamel's patients. This included the processes implemented in respect of Professor Eljamel's appraisals which did not include references to clinical outcomes.
59. The decision to institute supervision of Professor Eljamel's spinal surgery cases did not appear to effectively address the risks to all of his patients and was also not effectively implemented, resulting in risks to patient safety that could have been better mitigated by supervisory arrangements that were broader in scope and included intraoperative supervision. It is unlikely that if that had occurred the supervising consultant would have had orbital surgery experience. They may have suggested intraoperative guidance and histology to confirm the lesion which may have influenced the outcome.
60. The actions of Professor Eljamel in respect of central aspects of Mr. Kelly and Ms. Rose's care have contributed to significant psychological distress, and while NHS Tayside have taken decisions reflective of their accountability for monitoring and improving the quality of services provided, there were weaknesses in the Board's mitigation of some risks beyond Professor Eljamel's spinal surgery patients. There were also some failures in discharging their accountability in a manner that was in keeping with best practice relating to transparent, open and timely responses to questions - in ways that addressed the 'what' and 'why' of their decisions and actions; as well as openly accepting and describing their intentions relating to areas for improvement that they had identified.
61. NHS Tayside was accountable for the effectiveness of its clinical governance processes and while this was identified through internal review, this work has identified a need for ongoing improvements in respect of the way clinical governance and patient safety improvement actions were reported through the Board's processes in ways that robustly considered assurance of effective implementation and changes.

Recommended Actions

Recommended Actions for NHS Tayside

62. There should be mechanisms in place to ensure that anyone with an ongoing concern, interest or need for updates on the way in which learning, change and improvement actions are being implemented can access this information and any support required.

OFFICIAL SENSITIVE

63. NHS Tayside should review the way in which it identifies and measures the implementation and effectiveness of actions arising from internal and external review processes such as those commissioned in respect of Professor Eljamel's practice. This should include action plan content and subsequent relevant assurance through clinical governance processes to the Board's delegated committee with responsibility for clinical governance. This should be overseen by clinicians with lead responsibility for clinical governance in services.
64. NHS Tayside should outline what arrangements they have in place to ensure that all patients returning to theatre within 30 days are identified and discussed through relevant governance and improvement support processes.
65. A session should be offered by the Chair and Chief Executive of NHS Tayside to Mr. Kelly and Ms. Rose to discuss their experiences and consider ways in which the learning from all of the various reviews (and this report) can be implemented and provide robust assurance that changes made are resulting in reliable delivery of these processes. This should also consider any further action that can be taken to investigate areas of ongoing concern such as the involvement of a Consultant Urologist in Mr. Kelly's surgery and the unanswered questions in respect of any staff recollections recorded at the time in respect of Mr. Kelly's surgery.
66. Ms. Rose should receive an apology for the risks to patient safety that resulted from the decision-making about the scope and practical arrangements for the supervision of Professor Eljamel.
67. NHS Tayside should consider whether the current implementation of medical appraisal processes are sufficiently robust to ensure that the issues identified through the reviews relating to Professor Eljamel's practice are considered and captured in appraisal discussions and documentation, including the improved clinical governance processes that were reported to the Scottish Government in 2018.
68. NHS Tayside should ensure that Mr. Kelly and Ms. Rose are receiving the appropriate professional care and support to consider ways in which the significant distress associated with their experiences of being treated by Professor Eljamel can be addressed. It should be recognised that this may need to be supported by an appropriately skilled clinician who understands and is able to assist them in making sense of the links between their physical health, experiences of prior aspects of their care by Professor Eljamel and their beliefs about the causal and contributory factors to their experiences. This should include consideration of any interventions with the potential to consider workable and effective ways of minimising the ongoing negative and distressing impact of their experiences.
69. NHS Tayside should recognise that it is only through respectful, personalised and ongoing dialogue with Mr. Kelly and Ms. Rose that some of the unresolved and significant questions can be addressed in ways that help with the process of making sense of personally traumatic experiences.

OFFICIAL SENSITIVE

Recommended Actions for Scottish Government

- 70. Develop a process for the commissioning independent clinical reviews that is standardised across the DG Health and Social Care and available for officials to implement against agreed timescales and to take account of specific issues arising in procuring independent clinical advice.
- 71. Ensure that officials working across a range of policy areas implicated by this review are aware of the recommended actions and that responses inform further actions that form part of the cycle of review and assurance provided to Ministers in respect of quality and performance of the Board's services.
- 72. Require that NHS Tayside submit an action plan with appropriate measures of implementation and effectiveness in relation to the actions that will be taken in response to this review process.

Recommended Action for NHSScotland (from consultant neurosurgeons)

- 73. Establish a regional or national pathway for orbital tumours that identifies those with experience, clinical, surgical and radiological, in this area and encourages shared experience with opportunity for discussion and joint operating.
- 74. Guidelines for Consultant Supervision should be developed for NHS Boards where there is a need to implement supervision of a clinician following concerns in respect to the aspects of practice of Professor Eljamel that were inadequate.
- 75. Consider joining the National Neurosurgical Audit Programme.

Conclusion

- 76. NHS Tayside and Scottish Government should consider these recommended actions and provide Mr. Kelly and Ms. Rose with copies of actions plans that include measures of implementation and effectiveness for all actions identified and a clear description on how assurance of effective implementation will be measured and reported on.
- 77. We would like to thank Mr. Kelly and Ms. Rose for their contributions to this review. Contributions that were often and understandably very upsetting – and that both continue to experience significant levels of trauma, distress and impairment in their quality of life; highlighting the impact of the unresolved questions raised by their experiences and need for supportive dialogue and assurances of learning, change and improvement. We are also grateful to NHS Tayside for providing information requested during this review process and to the two independent Consultant Neurosurgeons for their work on the casenote review.

OFFICIAL SENSITIVE

Scottish Government
Healthcare Quality and Improvement Directorate
21 April 2022

Annex A

SUMMARY OF APPROACH – ELJAMEL REVIEW IN RESPECT OF JULIE ROSE AND PATRICK KELLY



- Casenote review – Terms of Reference – pages 2-3
- Liaison with NHS Tayside – pages 4-5
- Further discussions and support – page 6

OFFICIAL SENSITIVE

REVIEW OF CASENOTES AND OTHER GOVERNANCE DOCUMENTS –TERMS OF REFERENCE –

1. The Casenote Review will review the medical records of Mr Patrick Kelly and Ms Julie Rose and other relevant documentation in so far as they relate to the treatment received by both individuals from Professor Eljamel during the time that he was employed by NHS Tayside.

The reviewer appointed will be independent from NHS Scotland.

Purpose

2. The purpose of this review is **not** to consider issues such as causation and liability, those properly being the remit of the courts – but to identify the actions taken in respect of care, communication and engagement with Mr Kelly and Ms Rose and more widely to identify changes or improvements required to governance and improvement support processes within NHS Tayside, recognising that the observations and findings of the casenote etc review will be considered against the actions taken already to address the issues, risks and areas of improvement identified in respect of organisational processes impacting on care pathways and delivery.

To ascertain

- the chronology of events relating to Mr Kelly's and Ms Rose's neurosurgical care, the actions taken by Professor Eljamel and, when concerns were raised about these
- what treatment was carried out by Professor Eljamel in relation to Ms Rose and Mr Kelly
- what treatment, if any, was carried out by any other surgeon in relation to Mr Kelly
- what actions NHS Tayside took with regard to their engagement with both Professor Eljamel and in respect of Mr Kelly's and Ms Rose's care specifically, and the effectiveness and appropriateness of these actions
- whether there are lessons that could be learned by NHS Tayside and the wider NHS in Scotland.

In addition, the reviewer will be asked to consider

- what expectations (s)he would have in terms of the practice of a surgeon whose employing Board had considered the need to institute supervision on account of concerns about competence and quality of practice
- any other information NHS Tayside hold/held about Professor Eljamel including outcome of his appraisals
- to provide a view and opinion in respect of Mr Kelly and Ms Rose's unresolved questions about where "ultimate accountability" lies for the outcome of the treatment provided to Mr Kelly and Ms Rose.

Ms Rose and Mr Kelly may also provide the Investigator with a personal statement giving an overview of their medical condition past and present and present him or her with their own evidence.

OFFICIAL SENSITIVE

Outputs

3. The output from the Review will be a report addressing the bullet points at para 2 above insofar as the reviewer is able to determine the issues and a set of recommendations for further action.

The report and recommendations will be submitted to Professor Craig White, who will act on behalf of the Scottish Government. Professor White will share the report with Ms Rose and Mr Kelly before sharing it further as appropriate.

Methodology

4. The methodology used will be determined by the reviewer, but will take account of best practice in this area and will respect patient confidentiality and information governance principles.

Timeline

5. The timeline for the Review will be agreed between Professor White and the reviewer appointed and will take account of the need for this review to be undertaken as quickly as possible, but at the same time be sufficiently thorough to address the issues at paragraph 2 above.

Consent to access medical records

6. Mr Kelly and Ms Rose will be asked to provide written consent, in a form to be provided by the Scottish Government, so that their medical records may be accessed by the reviewer.

OFFICIAL SENSITIVE

LIAISON WITH NHS TAYSIDE

Ms Rose

- What was the timeline in respect of decisions about safety of Prof. Eljamel's practice and in particular the decision to suspend him?
- What did a response to Ms. Rose mean in terms of an email being 'lost in the system' and what impact did this have on the timescale of decision-making in respect of patient safety and further surgical care provided by Prof. Eljamel?
- What in practical terms did Prof. Eljamel's practice being supervised mean in terms of his practice?
- Was another neurosurgeon/ registrar called? Did he/she operate on Ms Rose the first time in place of Prof. Eljamel?

Mr Kelly

- Was it believed that Prof Eljamel was in theatre on 29 January 2007?
- What information was available through reviews carried out of staff recollections of who was present in theatre when it was reported Mr. Kelly was being operated on?
- What information was available through reviews carried out of the circumstances relating to the operation note relating to Mr Kelly?
- Did staff express any concerns during or immediately after Mr. Kelly's care in theatre?
- What was concluded to have happened in respect of Mr. Kelly's surgery?
- Was another neurosurgeon called/did he or she operate on Mr. Kelly instead?
- If Eljamel had not turned up for the surgery what was the Board's procedure for responding to such an occurrence? Is there any evidence that this happened that day?

General

- What consideration was given in relation to safe systems of work in respect of risks to patients identified as a result of complaints made about Prof Eljamel?
- What is the procedure for reporting incidents to the HSE?
- What are some of the reasons that NHS Tayside has reported specific incidents to the HSE?
- Was consideration given to involving Healthcare Improvement Scotland ? If so, in what way?
- If not, why not?
- Was advice sought from your Health and Safety team and if so what was this?
- At the time Ms Rose and Mr Kelly were under the care of Prof Eljamel what were the procedures and processes in place in respect of the review and handling of complaints in respect of individual clinicians ?
- When were changes made to this process and why ?
- When was the new Professional Governance Framework implemented and what specific aspects of review and learning in respect of Prof Eljamel's practice informed this?
- How has monitoring of the implementation and effectiveness of actions arising from reviews of complaints, adverse events and reports in respect of Prof Eljamel been progressed?

OFFICIAL SENSITIVE

- What processes have you in place for reviewing surgical outcomes and how are these considered as part of clinical governance and quality management processes and systems?
- What were the audit, quality and outcome monitoring processes in place in the neurosurgery service at the time Ms Rose and Mr Kelly were receiving care?
- How were data on return to theatre, surgical outcomes and adverse events within the neurosurgery services considered as part of the Board's duty of quality for monitoring?

Copies of internal reviews in respect of:

- Complaints and/or incident reviews in respect of Ms Rose and Mr Kelly's experiences
- Chronology of events in respect of Ms Rose and Mr Kelly's care and treatment
- Chronology of events in respect of NHS Tayside decision-making on issues identified within timescales relating to Ms Rose and Mr Kelly's care and treatment
- The review of the systems and processes undertaken by a Consultant of systems and process in support of the RO (as per letter of 2018)
- Any supporting documentation in response to the questions above

OFFICIAL SENSITIVE

FURTHER DISCUSSIONS AND SUPPORT

Separate from the casenote etc review and the liaison with NHS Tayside, further consideration will be given to how the following questions raised by Ms Rose and Mr Kelly can best be addressed with relevant organisations:

HSE:

- Has HSE been to visit NHS Tayside to investigate the large number of incidents related Professor Eljamel that have been reported to Police Scotland?
- What has the HSE done about these incidents?
- Has the HSE interviewed management, any staff, any patients, or families regarding Professor Eljamel?
- What reports are there on the above?
- What law applied to Mr Kelly and Ms Rose with regards to their safety under Professor Eljamel and NHS Tayside?
- Was the law being complied with?
- Who made sure the law was being complied with?

Healthcare Improvement Scotland

- What reports do Healthcare Improvement Scotland have on complaints/reviews for NHS Tayside from risks to patients from failings in management systems and Professor Eljamel?