

1 Thursday, 10 September 2026 2 (10.00 am) 3 (Proceedings delayed) 4 (10.09 am) 5 THE CHAIR: Good morning, please have a seat. 6 Mr Dawson, good morning. 7 MR DAWSON: Good morning, sir. The first witness this 8 morning is Karen Titchener. 9 THE CHAIR: Thank you. 10 MS KAREN TITCHENER (sworn) 11 Questions by COUNSEL TO THE INQUIRY 12 MR DAWSON: Good morning. You are Karen Titchener? 13 A. I am. 14 Q. And you are the Patient Safety Commissioner for 15 Scotland? 16 A. I am. 17 Q. Could I just ask you, Mrs Titchener, when you're giving 18 your evidence to try to speak into the microphones in 19 front of you, they're a little tricky, just so everyone 20 can hear what you're saying. Just one other thing 21 I want to make clear to you, I know from your written 22 evidence you have had some contact with patients who 23 are, some of them I think, core participants in this 24 Inquiry or otherwise. For present purposes the Inquiry 25 is avoiding mentioning the name of any patients for Page 1	1 commissioner. I understand you commenced in the role on 2 1 September 2025? 3 A. That's correct. 4 Q. And it's a full-time post, yes? 5 A. It is. 6 Q. You have a background, I think, in nursing? 7 A. That's correct. 8 Q. You are a registered general nurse and advance nurse 9 practitioner? 10 A. Yes. 11 Q. But you don't practice as a nurse, given your full-time 12 responsibilities in the other role? 13 A. That's correct. 14 Q. What is an advance nurse practitioner? 15 A. It's an extended qualification at a master's level, 16 sometimes it's done at a doctorate level, but it's to -- 17 so that you're practising at a different level. So you 18 learn advanced -- you learn physical assessment, you 19 learn anatomy and physiology and you're prescribing so 20 that you can work alongside doctors but still not called 21 a doctor but you are still allowed to diagnose and 22 prescribe. 23 Q. I see, so it's a higher level of qualification for 24 nurses which, as you advance through your career, you 25 might wish to try to achieve; is that right? Page 3
1 confidentiality reasons other than two patients, one of 2 whom I think you have had contact with, it's Jules Rose 3 and the other who you may have had contact with is 4 another individual called Pat Kelly. So if you feel, in 5 answer to any of the questions that you wish to refer to 6 patients, if you could otherwise try to respect their 7 anonymity other than those two names I'd be most 8 grateful. You could, of course, provide those names if 9 necessary to the Inquiry afterwards outwith this 10 session. 11 A. Thank you. 12 Q. You provided a witness statement dated 13 July this 13 year; is that correct? 14 A. That's correct. 15 Q. Could we have that up on the screen please, it's 16 PSC-00001. Is that your statement? 17 A. Yes. 18 Q. Could we go to page 29, please, and although it's 19 blanked out does your signature appear on that page? 20 A. It does. 21 Q. And are the contents of this statement true? 22 A. True. 23 Q. Thank you. As you have said, you're the patient -- just 24 go back to the front you page of the statement, thank 25 you very much. Thank you. You're the patient safety Page 2	1 A. Yes, yes. 2 Q. Does it require examinations being sat? 3 A. Yes, it's a full -- there's OSCEs and all sorts of 4 things and then obviously then written -- much written 5 work and a dissertation to round up the masters. 6 Q. I see, and if you reach that level it would enable you 7 to carry out more complex functions in your nursing 8 role? 9 A. That's correct. 10 Q. I see, thank you. 11 A. You can -- you're an individual practitioner working 12 within your licence of your expertise. 13 Q. Understood, thank you. In your career before taking up 14 the current post I understand that your career, at least 15 latterly, focused on health at home programmes, is that 16 right? 17 A. That's correct. 18 Q. Could you tell us a more about that, what they are and 19 what your role in connection with them involved? 20 A. Yes. So back at the turn of the century actually there 21 was an NSF for older people, the right care in the right 22 place at the right time for the right people. And that 23 said there's a lot of care that's happening in hospital 24 that with the right expertise in the home that could be 25 given at home. So even then it was looking at bed Page 4

1 capacity and looking at A&E waits and things like that 2 and thinking how could we stop that care hitting 3 hospital. 4 So I have been involved in building programmes, both 5 admission avoidance and early discharge and that's 6 a multidisciplinary team including GPs, geriatricians, 7 nurses, physiotherapists, pharmacists and it's basically 8 taking patients on to a programme that's step-up care or 9 step-down care from their usual care. So if they had 10 hit the emergency -- the A&E you'd be taking them out to 11 give that care that may have happened in a hospital bed. 12 If it's from a GP and they're wanting to refer them to 13 the hospital, again you could step in and give that 14 care. So it's a higher level care than normal community 15 nursing care would be giving and for a very short period 16 of time. 17 Q. Right. You mentioned there being an impetus behind that 18 to do with capacity of beds in hospitals but presumably 19 the systems are designed to try to promote the 20 therapeutic advantages to individuals of being at home 21 rather than in hospital, no? 22 A. Yes, but I'm not sure that concept has totally embedded 23 because, you know, when patients are heading to hospital 24 they know that they're not very well and their 25 expectation is potentially that that care will be Page 5	1 conditions. Would such programmes be suitable for those 2 individuals? 3 A. No. If somebody has a stroke or, you know, has got 4 something going on neurologically there would be other 5 programmes they would be referred to following their 6 discharge. But this isn't about depriving people of the 7 appropriate care, it's about providing care that could 8 otherwise happen at home. 9 Q. Thank you. In your broader experience in the nursing 10 profession do you have any experience of working in 11 hospital surgical settings? 12 A. No. 13 Q. Is it correct to say that before taking up your current 14 position you hadn't previously worked in Scotland? 15 A. That's correct. 16 Q. Has, in your -- I understand that you've been in the 17 role for about a year now and we'll look at this in 18 a bit more detail in a moment, that's involved quite 19 a lot of setting up the arrangements for the post to be 20 able to be delivered properly; is that correct? 21 A. That's correct. 22 Q. Because you're the first person to hold this position in 23 Scotland? 24 A. Yes. 25 Q. How have you found the fact that you didn't previously Page 7
1 happening in hospital. So I think more recently it's 2 becoming more acceptable. I think people feel that if 3 they're getting care at home it's lesser care than they 4 would get in hospital but we know, particularly with 5 older people, the care that they get in hospital they 6 usually end up decompensating and, you know, becoming 7 less mobile because they take on the role of the 8 patient, and they sit in the chair and they don't go and 9 get their cup of tea. 10 So I think it's becoming more acceptable certainly 11 but I would still say it's not the course of least 12 resistance, the course of least resistance is still to 13 admit the patient. 14 Q. Do such programmes only involve certain types of 15 patients? 16 A. So in Scotland they have chosen for it to be care of the 17 elderly. So care of the elderly physicians would be 18 leading that and frailty, but elsewhere in England, when 19 I did the programme in London, that was for over 18 so 20 it was for anybody. So, and again, that was to reduce 21 bed capacity and we had targets to hit so many patients 22 to try and relieve the pressures. 23 Q. Understood. Obviously in this Inquiry we're 24 predominantly interested in the field of neurosurgery. 25 That tends to involve people who are in quite serious Page 6	1 work in Scotland in the role so far, in particular with 2 regard to the possible disadvantages of not knowing the 3 Scottish system but the possible advantages of coming 4 to it with a fresher perspective? 5 A. So I think both of those are true. I think I had to 6 very quickly understand NHS Scotland which was very 7 different to NHS England, I had to understand obviously 8 the health system and the boards but I was equally able 9 to come with fresh eyes and think: oh, I wonder why 10 you're doing that. So I think it was a positive as well 11 as a negative and I never see anything as a negative 12 anyway, I just had to learn quicker than I would have 13 had if I had been around in Scotland. And remember, 14 there's no footprint for this so it's -- you're walking 15 on fresh snow every day. You've got an act but you're 16 having to decide yourself how you're going to build the 17 programme. 18 Q. Absolutely. And that process of learning about the way 19 that the systems are organised in NHS Scotland is very 20 much a process in which we're involved ourselves. So 21 have there been any -- from your perspective of patient 22 safety, have there been any features of that 23 organisational structure which have struck you as 24 particularly conducive towards maximising patient safety 25 or perhaps potentially problematic in that regard? Page 8

1 A. I think -- I think Scotland is improvement-rich but 2 assurance -- there's a gap, I think, between independent 3 assurance and that improvement arm that has happened. 4 I think there are many organisations out there that are 5 attempting to improve things. I think there are things 6 that could make it better, you know, regulatory bodies 7 that -- Scotland doesn't have a QCC, for example, the 8 quality care commission that England has. It does have 9 Healthcare Improvement Scotland which is -- for the NHS 10 is an inspector not a regulator. 11 Q. So as I understand it, you'll correct me if I'm wrong, 12 the quality care commission in England would have 13 a function in the oversight and regulation of healthcare 14 providers; is that correct? 15 A. No. 16 Q. No. Explain to me the difference. 17 A. Sorry, so it is -- it does inspections of hospitals 18 and -- but it has more power behind it to then enforce 19 the output. 20 Q. In what way? How would that work? 21 A. So it's got regulatory powers. So it can prosecute, it 22 can -- obviously it tries to get people to change, as 23 does Healthcare Improvement Scotland because obviously 24 when they do an inspection they give recommendations. 25 I think those recommendations are recommendations and Page 9	1 been learning about the organisation of the delivery of 2 healthcare in Scotland and no doubt, just as you've done 3 so, there appears to have been a major change announced 4 to that. Last week it was announced that the 5 14 territorial health boards would effectively, as 6 I understand it, be disbanded and moving to a two health 7 board system. First of all, is there anything you 8 can -- do you have an understanding of how that's going 9 to work? Is that something you've been told about? 10 A. I have no idea how it's going to work. I think it was 11 announced but with no footprint as to how that is going 12 to work. 13 Q. Yes, as a policy if you like but perhaps it needs to be 14 worked through. But in trying to think about this 15 I thought it was probably unlikely to have an effect on 16 your role, given where you sit, but do you think it is 17 likely to have an effect on your role? 18 A. Well, I will certainly be -- I have concerns that going 19 from 14 to two, or I think it's actually 11 to two and 20 then the islands are potentially going to be boards as 21 well so it will be three boards, but for me it's 22 around -- you know, I'm the Patient Safety Commissioner 23 for Scotland. So I need to make sure that whatever 24 changes are happening it doesn't increase the risk to 25 patients. So therefore I will want to be watching very Page 11
1 there's no mandatory or statutory power for that to be 2 enforced. 3 Q. So is that what you mean by the culture being 4 improvement-rich but independent assurance poor perhaps 5 that you have bodies like Healthcare Improvement 6 Scotland that are perhaps doing good work, investigating 7 things, creating recommendations, but when you get to 8 the point of those having to be enforced that's where 9 there's perhaps at least a difference with England or 10 perhaps a lacuna in the system? 11 A. Yes. 12 Q. Thank you. That's something which we will be exploring 13 with other witnesses more directly involved in that 14 field but that's very helpful. And do you think that 15 that lacuna that you've identified or that difference 16 has an effect on patient safety? 17 A. I think it has the potential to have. I haven't got 18 evidence of that but it's just something that I have in 19 my head, so please understand this as my perspective. 20 Q. Yes. Of course. 21 A. So I have to look at the areas out there that 22 I'm concerned about and that -- you know, that we need 23 to change so that was one of the areas I had been 24 thinking about. 25 Q. Organisationally speaking, you've told us that you've Page 10	1 carefully the decisions that are being made and make 2 sure that the patient -- it's patient-centric because 3 this shouldn't be all about money, this should be about 4 providing better and safer care. So I want to make sure 5 with -- I don't know how I will -- I'm not sure I'll be 6 involved in the decision-making but I certainly -- from 7 our office we will be amplifying the voice of the 8 patient where there's concerns raised. 9 Q. Thank you. Is it your perception at the moment that 10 it's all about money? 11 A. I don't know. That's what's it's being presented as but 12 it has to be -- it has to be about more than that. 13 Q. Thank you. Because you've helpfully pointed out, that 14 was my understanding too, that there will be a third 15 health board if you like for the islands. Inherent in 16 that announcement seems to be a recognition that the 17 geographical, perhaps other considerations, related to 18 the islands needs to be treated differently but I think 19 it's been voiced politically already there are some 20 concerns about having a two-board structure on the 21 mainland, if you like, would appropriately reflect the 22 local requirements of patients in different parts of 23 Scotland. Is that a consideration that you think you 24 will take a keen interest in? 25 A. Yes, I mean I think there's already inequities of care Page 12

1 in rural areas in Scotland, not just in the islands. So 2 again, I think we have to make sure in whatever 3 decisions we're making and centralising things that that 4 doesn't mean that care is going to be provided further 5 away from people's home. 6 Q. Because the geographical area that's covered by any 7 healthcare provider can stretch it, can make it less 8 patient-centric, can make it less efficient. Is that 9 a phenomenon that you're familiar with? 10 A. Yes. 11 Q. Thank you. I understand -- to talk a bit more about the 12 role itself, thank you for that. I understand that the 13 role was created, albeit it came about quite a lot 14 later, as a result or in response to the independent 15 medicines and medical devices safety review, commonly 16 called the Cumberlege review, is that right? 17 A. That's correct. 18 Q. And it reported in 2020? 19 A. Yes. 20 Q. And the reference we've given to the document that 21 you've provided is PSC-00007 and in that review, as 22 I understand it, it was found that patients' concerns in 23 the matters they were looking at had often been ignored 24 or dismissed; is that right? 25 A. That's correct. Page 13	1 A. Yes. 2 Q. Just zoom in a bit on 3.10, thank you. It says: 3 "Scotland committed by way of the Programme for 4 Government 2020 ... to establishing a national patient 5 advocate. Therefore, the role was created to strengthen 6 the patient voice and provide independent scrutiny of 7 safety addressing system-wide failures rather than 8 isolated incidences." 9 How does your role provide independent scrutiny of 10 safety with a focus on system-wide failures as opposed 11 to isolated incidences? 12 A. Yes, and that's what differentiates this office from the 13 Ombudsman because the Ombudsman in Scotland looks after 14 individual cases, so I think that's why they were trying 15 to separate it out. So the office is there to hear the 16 voice of the patients and when -- obviously patient 17 complaints have to follow the due process, so you know, 18 go to the board, go to the Ombudsman but when patients 19 are writing to us if we think it is something systemic, 20 on when other processes are going on, we will still 21 start our process of looking to see. And if I'm honest 22 most patient complaints are never about an individual 23 person or an individual thing, so actually you could say 24 most things that patients are talking about are to do 25 with system level. Page 15
1 Q. And in fact, in the circumstances of that Inquiry, that 2 this had in fact led to avoidable harm and systemic 3 failure? 4 A. Yes. 5 Q. The focus of that Inquiry was on medical devices of 6 various different types, I think? 7 A. Yes. It was medicines and medical devices because those 8 were the -- both sodium valproate and the pelvic mesh 9 were the two big things that came out in that. 10 Q. Yes, and you say -- just to be clear, the ultimate 11 position that you now hold isn't limited to those sorts 12 of considerations, medicines or medical devices, it is 13 a broader remit, isn't it? 14 A. That's correct, it is a much broader remit. 15 Q. So in case anyone misunderstood although the post came 16 out of an inquiry related to a more specific subject 17 matter, the recommendation was for a patient safety 18 commissioner that would cover patient safety across the 19 board? 20 A. Yes. 21 Q. And that is what, in fact, has been created and the role 22 you now occupy? 23 A. Yes. 24 Q. You say at paragraph 3.10 of your report -- if we just 25 go to that. Page 14	1 Q. We'll return to that very important theme in a moment, 2 Mrs Titchener. 3 THE CHAIR: Mr Dawson, can I clarify one point, I think you 4 said it but I wanted to check I didn't misunderstand it. 5 If a patient wishes to approach you with a complaint of 6 whatever kind, it is not a pre-condition of their doing 7 so that they should have been through a complaints 8 process already to the point of resolution? 9 A. It is. We encourage people -- so, often if it is 10 looking like it's an individual complaint, you know -- 11 I don't want to give an example, but if it's 12 an individual thing then we make sure that they have 13 done that complaint to the board. But even if it's 14 a system thing, we still want the board to be aware that 15 the patient has got that complaint. 16 But what is happening at the minute is because there 17 is a delay in -- so boards might say: we can't get back 18 to you for nine months, I think the Ombudsman as well 19 are very, very busy. And so if they're saying: we can't 20 get back to you and patients are feeling like it's a now 21 issue, then that's when we would get involved because we 22 don't want to wait nine months. If somebody turned up 23 to an A&E and there were no oxygen masks, you know, 24 I'm not going to wait for the board to do that 25 investigation. Page 16

1 THE CHAIR: Thank you. 2 MR DAWSON: For the sake of clarity, the Ombudsman you 3 mentioned earlier is the Scottish Public Services 4 Ombudsman. 5 A. Yes. 6 Q. You mentioned earlier an interesting point that quite 7 often, in reality, what might appear to a patient to be 8 an individual complaint actually involves systemic 9 matters but they may well not know that, is that right? 10 A. Yes, the patient may not realise. But also even if it's 11 not, it still adds to our story to look at systemic 12 because it's like: oh, that's another patient from, you 13 know, who is saying something about that department. So 14 even though it may be, on the surface, an individual 15 complaint it could add to the picture of actually is 16 there something going on systemically. So we always 17 have to look at that. 18 Q. Indeed. You may have answered my very next question 19 which was to be how -- given the systemic focus of what 20 you do, given the fact as you have explained to the 21 Chair individual patients can approach you directly, how 22 you would translate, if you like, an individual 23 complaint into something systemic and therefore falling 24 within your remit? 25 A. Yes, so as you know there's a complicated Act for the Page 17	1 present in other similar Inquiries which is the belief 2 on the part of an individual where they are dissatisfied 3 with their care or something has gone wrong or they've 4 suffered an adverse outcome, that they are the only one 5 who has been affected this way, whereas in reality there 6 are other people feeling exactly the same way. That is 7 a common phenomenon where groups of patients come 8 together, as I understand it was the case with patients 9 here, but is your office, whether at the moment or once 10 the framework is set up, is part of its function to try 11 to join those people together or join the dots together 12 of their experiences to try to recognise that there may 13 be something systemic going on here? 14 A. 100%. 15 Q. Yeah. The other aspect of this that I wanted to address 16 is something you touched on yourself, I think you 17 mentioned the words a "now" issue because I wanted to 18 raise with you the possibility -- and again I think this 19 is also the experience of patients in this Inquiry and 20 in other similar ones -- that there is a danger that 21 that process, even with the assistance of someone in 22 your office, can take a long time. So it may be to 23 build up the pictures and join the dots, that that could 24 take a long time. Is that possibility and that danger 25 something that you're conscious of? Page 19
1 Patient Safety Commissioner. So now that I have 2 an officer for it, we are putting together a framework 3 of how we address complaints when they come in. So is 4 this just an informal approach or, as the Act says, do 5 we need to do something more formal with this. So we're 6 putting together a framework, a legal framework to make 7 sure that our office is acting within the framework of 8 the Act of the Patient Safety Commissioner. 9 Q. I see, but is it then within your discretion, if you 10 like, to decide how you go about translating the 11 individual experience into something systemic? Because 12 obviously you've got to work within the systemic remit 13 but how that actually manifests itself, is that a meter 14 for you to determine? 15 A. Yes, so within the framework we're looking at triggers 16 of escalation. So is this just something I want to talk 17 to the board about in an informal way or -- whoever the 18 complaints come in, I'm using boards as a generality. 19 Q. Of course. 20 A. Or is this something actually that's very serious and we 21 need to then trigger an investigation. 22 Q. Because there's two aspects that I'd like to explore 23 with you, the first of which is a phenomenon, I think, 24 that we have heard evidence about in this Inquiry and 25 indeed as I understand it is a phenomenon that's been Page 18	1 A. Very. 2 Q. And what -- at least at the moment as you're formulating 3 your framework, what is your thinking around what you 4 can try to do to try to accelerate that process? 5 A. You know, I think, you know we are a small office so for 6 us to be firefighting every "now" emergency or patient 7 safety risk that happens, I'm not sure what we could do 8 for that. So I think this is about all the systems that 9 are working together. You know, we've got Healthcare 10 Improvement Scotland and I don't want to talk about what 11 they do but they have turnaround, they can go in and 12 help people. If a board is struggling, they can do -- 13 they can go in and help but I'm sure you'll hear more 14 from them now and they'll say I don't know what I was 15 talking about. So for us I think, if it is literally 16 something that I feel is of imminent danger to 17 a patient, I would be pick picking up the phone to the 18 board there and then to escalate that and if I needed 19 to, escalate it to Scottish Government or/and HIS. 20 Q. Because one other aspect of the timing aspect of the 21 "now" issue that I wanted to raise with you -- 22 I'm slightly loathe to delve too far into the Act 23 because it is a complicated framework, as you have said 24 and involves a lot of practical steps that you have 25 been, I think, occupied with over the last year or so Page 20

1 but there are some aspects that I think are worth 2 highlighting and are interesting to explore with you. 3 If we could have a look at that please, ELJ-00559. This 4 is the Patient Safety Commissioner for Scotland Act, 5 which is the statute which creates your office, isn't 6 it? 7 A. That's correct. 8 Q. And in section 2 it sets out that: 9 "The Commissioner's general functions are. 10 " ... to advocate for systemic improvement in the 11 safety of health care, and. 12 " ... to promote the importance of the views of 13 patients and other members of the public in relation to 14 the safety of health care. 15 " ... In exercising [these] functions, 16 the Commissioner may in particular. 17 " ... gather information, for example patient 18 feedback, relating to the safety of health care. 19 " ... keep under review, analyse and report on 20 information obtained." 21 And over the page: 22 " ... make recommendations for systemic improvements 23 in the safety of health care. 24 " ... promote public awareness of safety practices 25 in relation to health care. Page 21	1 incidents may inform the improvement of the safety of 2 healthcare in the future? 3 A. Yes. 4 Q. So, is that right? 5 A. Yes. 6 Q. Yes, so you have the ability to look at -- as we are -- 7 past incidents in order to try to work out whether that 8 might help you make recommendations to better healthcare 9 in the future? 10 A. Yes. 11 Q. Thank you. 12 A. I think this relates to -- because obviously everybody 13 who talks to me, it's in the past. 14 Q. Of course. 15 A. So I think this was potentially talking about the 16 redress and things like that for the sodium valproate 17 and the mesh, of which I happily support the people but 18 it's not my role to fight for the redress. 19 Q. Yes. It's to make clear, I think, that there are limits 20 on what it is your role should rightly do so as to allow 21 you to focus on particular areas and therefore do the 22 best job possible in those areas? 23 A. Yes, but also we have to learn from past failings and 24 therefore you have to look back to address the future. 25 Q. Thank you. Another feature of your role which you have Page 23
1 " ... promote co-ordination among health care 2 providers and public authorities with functions that 3 relate to health care." 4 And Section (3), it states -- which is the bit I'd 5 like to focus on for present purposes: 6 "It is not the Commissioner's role to resolve, or 7 facilitate the resolution of, grievances arising from 8 past incidents; accordingly, the Commissioner has no 9 power to. 10 "... make awards, or provide other form of redress, 11 for harms suffered. 12 "... assist individuals in seeking redress for harms 13 suffered. 14 " ... [or] opine on the action that another person 15 ought to take in respect of an individual in light of 16 a past incident." 17 We'll probably talk about some of the other 18 component parts but just as we're on the timing aspect, 19 the subsection (3) imposes, no doubt very deliberately, 20 on part of the legislature prohibition, if you like, on 21 you looking into past incidents. So your role is very 22 much a forward-facing one, is that right? 23 A. That's correct. 24 Q. It is, however, I think, possible for you to take 25 cognisance of past incidents insofar as those past Page 22	1 emphasised and is apparent from the Act, one can see, if 2 we go back to the statement, please, paragraph 3.22, 3 this is the importance of independence. And it says 4 there, you say there: 5 "The need for independence also flows directly from 6 the role's origin. The Cumberlege Review found that 7 patients had repeatedly raised legitimate safety 8 concerns that were not heard or acted upon by the 9 organisations responsible for their care. An office 10 that sits within, or is answerable to, those same 11 organisations cannot credibly fulfil the function of 12 amplifying patient voices and holding systems to 13 account. Independence is the condition that makes the 14 role trustworthy to the public it serves." 15 Now, we could probably spend the rest of the day 16 analysing aspects of that, particularly in the context 17 of how this Inquiry came about, but obviously the role 18 and -- the role grew out of evidence heard and accepted 19 by the Cumberlege Review, but can you tell me, in terms 20 of how you've interpreted your role, how important 21 independence is to it? 22 A. I am -- I guard it with my life, my independence. It's 23 very, very important because I have no skin in the game 24 around any person who has -- when harm has happened to 25 patients. So I think it's very important that I'm not Page 24

1 answerable to Scottish Government, I'm answerable 2 to boards or to HIS. Once a year I write a report to 3 parliament, but I think in order to advocate for the 4 patients it's fundamentally essential to this office 5 that we remain independent. 6 Q. And again, there's a resonance of aspects of that 7 paragraph in what evidence we have heard here and 8 aspects that we are examining that it has been, I think, 9 that the origin of your office, as I understand it, 10 flows to an extent from previous experience of others 11 who have tried to have issues investigated but when they 12 have had those investigated within, or within bodies 13 associated with the body into whom the investigation -- 14 into which the investigation was taking place, have 15 ultimately been dissatisfied with the outcome being 16 under the impression, as they were, that that was not 17 a properly independent investigation. Is that 18 an understanding of -- is that your understanding of the 19 origin, if you like, of why independence is ingrained in 20 your office as it is? 21 A. Yes. 22 Q. And indeed in your approach to it? 23 A. Yes. 24 Q. As far as practical measures are concerned with regard 25 to independence, you've mentioned you don't answer to Page 25	1 A. Yes, I now have a team of four including myself. 2 Q. Yes, and we'll get on to other aspects of people who 3 help new due course but it's quite unpredictable, 4 I suppose for you at this stage, to be able to say what 5 your office in your view might require to do because you 6 haven't been able yet to understand, given that you've 7 been setting up the office, the full scale of patient 8 safety issues that exist in Scotland, is that right? 9 A. That's correct. 10 Q. So if hypothetically it were to be the case that you 11 were to find that there were very extensive issues, many 12 of which you felt you could assist with or try to 13 uncover or recommend solutions for, how would you go 14 about getting more funding to enable you to do that? 15 A. Yes, and also we don't even know if the Act is enough to 16 give us the power. So there are lots of things that 17 we're looking at even now. 18 Q. I understand. 19 A. So part of reporting to parliament, which we only do 20 once a year in our annual report which I'm due to 21 publish in the next few days but we also, once a year, 22 go to the health and sports committee. So if we were 23 looking for extra funding we would have to be -- it 24 still has to go through the corporate body but we can 25 also petition in the health and sports committee and Page 27
1 the Scottish Government. You answer to the Scottish 2 Parliament, as I understand it. How does that work 3 practically in terms of, for example, where does the 4 funding for your office come from? 5 A. From Scottish Parliament. So there's a corporate body. 6 SPCB is the corporate body. 7 Q. Yes, the Scottish Parliament Corporate Body? 8 A. That's correct. 9 Q. Without getting into wishing to get into the bricks and 10 mortar of the politics, but where does the Scottish 11 Parliament Corporate Body get its money from? 12 A. I don't know, sorry, that's -- I presume Scottish 13 Parliament and maybe assuming is means wrong, but 14 Scottish Parliament have a different pot of money to 15 Scottish Government. 16 Q. Yes, but ultimately, does the money not come from the 17 people that's collected in taxes that goes to the 18 government and is then allocated to the department? 19 A. Potentially. I'm sorry, I haven't investigated that. 20 Q. That's okay. You mentioned earlier you having 21 an office. I think you tell us in your statement that 22 it started off with just you and you've literally had to 23 build it up really from the ground up, is that right? 24 A. Yes, yes. 25 Q. And you've now got a small staff -- Page 26	1 then obviously the health secretary as well. 2 Q. Right so the idea of that is that there's a public 3 accountability aspect of that to the public -- 4 A. Yes. 5 Q. -- rather than to the government and of course you're 6 accounting to the parliament through your annual 7 reporting mechanism. But also those would be fora in 8 which you could raise issues about the level of your 9 funding and the possibility that you might need to have 10 more for the next year or something like that? 11 A. Yes. 12 Q. Understood. Just staying on the subject of 13 independence, it is, I think as you have explained 14 yourself, your intention to be independent is very 15 important to everything you do but it's also important 16 to be seen to be independent for patients, isn't it? 17 A. Yes. 18 Q. Why is that, do you think? 19 A. Because if patients have been harmed by -- you know, by 20 a system then it's very important for me to not be part 21 of that system. You know, I think fundamentally how we 22 do significant event reviews and things like that you 23 can understand the patients' concern if you were -- if 24 you did an internal review, where is the independence in 25 that? Page 28

1 Q. And it is I think a matter of trust and confidence in 2 the outcome, isn't it, that the person doing it is doing 3 it in a truly independent fashion? 4 A. Yes. 5 THE CHAIR: Not marking your own homework. 6 A. That was on the tip of my tongue to say but I'm trying 7 to refrain. Yes, I think you're always going to get 8 an A star if you mark your own homework. So I think 9 that is something fundamentally that we need to look at 10 in Scotland to make patient care safer. 11 MR DAWSON: Could we expand on that a little bit as to what 12 aspects of the system do you think perhaps lack 13 independence or lack being seen to be independent? 14 A. Well, you know, I think when harm has occurred it's not 15 just about looking about what went wrong, it has to be 16 around the system, proving that lessons have been 17 learned and things are going to change. Whether that's 18 one significant event that's happened or whether it's 19 ten. Which is what I was talking about earlier on is 20 that assurance gap. So I think we're improvement-rich 21 because it's a paper exercise: this is what we're going 22 to do, but that assurance of, has that actually 23 happened, is where the gap is. 24 Q. And one aspect of the evidence that we've seen in this 25 Inquiry is around systems like that requiring to provide Page 29	1 Q. And I think, from what you've said, independence is 2 an important part in providing the assurance to the 3 extent that one can because it can't be a guarantee but 4 to make it as robust as possible, independence is a key 5 factor, is that right? 6 A. I think so. 7 Q. You mentioned there is another aspect that we have 8 an interest in which is apologies. I don't know whether 9 this is something that's come up directly in your role 10 or something you have wider experience of but when 11 apologies are made by healthcare providers, what are the 12 sorts of characteristics that you think those apologies 13 should have in order to be meaningful? 14 A. I think when a patient writes a complaint letter they 15 have to have a reason for doing it. So -- and so that 16 needs to be taken seriously. So whether it is just, 17 "I had to wait ten hours and there was no bathroom for 18 me", you know, whether it is a low-level complaint or 19 whether it is actually that that true significant harm 20 happened, it doesn't matter at the level of the 21 complaint. The approach should be exactly the same, 22 that the patient voice is heard, that it's not just -- 23 it's not a "complaint" but it's actually them trying to 24 contribute to the care that that institute is giving 25 them. Page 31
1 that assurance, not even just for the individual patient 2 but so that others in future will not suffer the same 3 outcome. That's a phenomenon we've seen in evidence 4 from patients on a numerous occasions where those sorts 5 of systems of investigation couldn't put anything right 6 for them but they felt it was important that there be 7 such assurance given that this would never happen to 8 anyone else. Is that a phenomenon that you recognise in 9 patient attitudes to these sorts of things? 10 A. That is almost every patient when they're making 11 a complaint. Or two things: one, a recognition and 12 an apology if you like and, two, they just don't want it 13 to happen to somebody else. So a patient's intention in 14 complaining is always almost 100%: look, I just don't 15 want this to happen to somebody else, as well as 16 a recognition like: look, we did a bad job and we got 17 that wrong and this is what we're doing. And I think 18 patients do need that assurance to say: because you 19 spoke up, here's what we're going to do differently the 20 next time. 21 Now, there's no guarantees in life that things won't 22 happen again. I don't think we can ever assure people 23 100% but what we can do is do our best and implement 24 change to make sure that that serious harm doesn't 25 happen repeatedly. Page 30	1 So I think it's very important that that is 2 recognised very early on to say: I really appreciate you 3 taking time, you know, to write to me. Because what 4 I worry about in Scotland, with a very diverse 5 population, is at the minute, people that get through to 6 my office are very articulate, can say what they mean, 7 can write me an email and I worry about the patients who 8 aren't so articulate. So that is why we're going out 9 into communities and holding town halls to people who 10 might not have an email. So how are we hearing from the 11 whole population to make sure that everybody's voice is 12 amplified when it comes to this? So I think with 13 regards to complaints, I think at the early stage it's 14 very important to take it seriously whatever level the 15 complaint is at. 16 Q. There's a lot of very interesting material in there, 17 Mrs Titchener, but if I could drag you back to my 18 original question which was the important 19 characteristics perhaps of the outcome of a process like 20 that, which was apologies. If apologies are the 21 ultimate outcome of a process like that, then what are 22 the characteristics, do you think, that an apology 23 should have to serve its purpose? 24 A. Well, an apology, for me, should be done in person. It 25 shouldn't be done on a letter that's sent to you. But Page 32

1 it's more than that, it's understanding where the 2 patient is coming from. And apologies hold no weight if 3 they don't come with an action. So I can apologise to 4 you for something that happened but actually if I'm not 5 then saying to you, "And just to assure you that because 6 you have had the courage to write to us, we have -- we 7 are trying to change that process". So I think some of 8 the stuff about this should be, you know, maybe 9 listening to patients more and maybe having active 10 patient groups and patient voices within boards so that 11 we can make that change. 12 Q. Thank you. 13 A. I think we can't lose the voice of the patient. 14 Q. And on the subject of the complaints process, which you 15 helped us with a moment ago, you mentioned that you 16 consider it to be an important feature of a complaints 17 process that the party raising the complaint or the 18 issue is taken seriously. I took it and took -- that 19 the reason for doing it should be understood, I took 20 that to mean that the party making the complaint should 21 be believed; is that correct? 22 A. Yes, 100%. 23 Q. Is that an important feature? 24 A. It's a very important feature. There has to be 25 an acknowledgement and a recognition that -- and your Page 33	1 A. Yes. 2 Q. Could you give us some colour to that, some information 3 about where that arises in a broad sense at least? 4 A. Yes, well, it is the inequity between rural and urban 5 health provision and, you know, decisions being taken 6 without looking at risk mitigation or without engaging 7 with local populations. And, you know, part of what 8 I have done, I'm actually trying to visit all the 9 boards. I have got through seven and I did rural first 10 because that was where the loudest voice was coming from 11 and the loudest concerns were coming from, so we decided 12 to visit the rural practices. 13 So I have driven the road from Inverness to Wick so 14 I know, you know, if you're in labour what that road 15 feels like, not that I was in labour, but you know, 16 I wanted to walk the walk so that I could understand 17 when patients were telling me things that I said: oh 18 yeah, I know that road, that would be a tough road to go 19 through. So that you know those are the kind of things 20 that we're hearing. 21 Q. Thank you. I'd just like to return to a matter we 22 touched on briefly earlier but you expand upon helpfully 23 in your statement, which is the means by which you are 24 able to comply with the statutory remit you've been 25 given to look at things which are systemic, to translate Page 35
1 truth is your truth and you have to remember that. So 2 if that is what I have perceived happened then that's 3 why you need to listen to the patient. Every complaint 4 that comes into our office we try and have an in-person 5 or in-teams meeting because sometimes what's said on 6 paper doesn't actually tell the true story. So we try 7 and actually meet with people because we want to make 8 sure we're understanding where they're coming from and 9 we're hearing the heart of why they're feeling that 10 something went wrong. 11 Q. There might be a multiplicity of reasons for that, 12 I suppose, but one might be a matter you touched on 13 earlier which is the systems, as you perceive them in 14 Scotland as I understood your evidence, being perhaps 15 better geared towards those who are more articulate and 16 perhaps not to the full range of individuals who may 17 wish to raise issues or complaints. Has that been your 18 experience? 19 A. Yes. 20 Q. And that, I suppose, is a facet of the wider issue of 21 health inequality? 22 A. Yes. 23 Q. Is health inequality more broadly something that, in 24 your experience so far of the Scottish system, you've 25 come across? Page 34	1 individual experience into systemic issue. And so you 2 help us with that at paragraph 3.27 of your report. 3 If we could just scroll to that. I'm just going to 4 read through a few paragraphs here. You say: 5 "These approaches are designed to support the 6 identification of systemic issues and to promote 7 learning and improvement across the healthcare system. 8 The Act does not require me to wait for a pattern to be 9 formally established before I can act. My functions 10 include gathering and analysing information, publishing 11 reports, and initiating formal investigations and I can 12 exercise all of those on my own initiative. Individual 13 patient experiences are not simply anecdote. They are 14 data. When a patient tells me that their concerns were 15 not listened to, that a risk was not communicated to 16 them, or that something went wrong and no one explained 17 why, that is a signal. When I hear the same signal 18 repeatedly across different patients, different 19 settings, different NHS boards it becomes a pattern. 20 And patterns of that kind are exactly what my role 21 exists to investigate and act upon." 22 Then at paragraph 3.30, you say: 23 "The threshold I apply is whether what I am hearing 24 reflects a failure of systems, processes, governance, or 25 culture rather than an isolated individual incident. Page 36

1 A single adverse event may be a tragedy. The same type 2 of event recurring across different settings, or 3 a review process that consistently fails to identify 4 root causes or change practice, it is a systemic 5 failure. That is where my remit begins. 6 "I would add one further point. The patients who 7 contact me do not always frame their experience in 8 systemic terms [when] they are describing what happened 9 to them, and that is entirely right. Part of my role is 10 to hold their individual account with care and respect, 11 while also asking the wider question it raises. Those 12 two things are not in tension. The individual 13 experience is often the most powerful evidence that a 14 system has failed, and it is my responsibility to make 15 that connection visible." 16 So there's a lot of very interesting thinking there 17 around how you deal with this dilemma, I think, of 18 trying to take individual experience but to try to work 19 out whether that is a signal that it triggers your 20 systemic remit, I think? 21 A. Yes, that's correct. 22 Q. And how -- I think what you said earlier is I think in 23 relation to, for example, an individual communicating to 24 you there were no oxygen masks in a hospital or 25 something. It is possible I think for a systemic Page 37	1 an insufficient amount of attention to that? 2 A. Yes, I think there is -- you know, there is good 3 practice but I think there are certainly gaps. So yes, 4 obviously clearly you know 20,000 people I think 5 complained about mesh before something happened. So 6 I think, you know, between the four nations, patients 7 weren't being heard. It's not unique to Scotland but 8 for Scotland certainly -- and Scotland have taken the 9 position more seriously than anybody else. 10 Northern Ireland and Wales actually have gone for 11 a commissioner and England, the commissioner is only on 12 medical devices and medicines. So, you know, I'm very 13 grateful for the fact that Scotland has taken this role 14 so seriously and actually said: no, we will give you 15 independence and therefore the authority that that -- 16 and the reassurance that that gives to patients. 17 Q. Because my understanding was that Lady Cumberlege 18 identified that there was a need for this role to be 19 created because there was a gap in the system? 20 A. Yes. 21 Q. The gap may not be that there weren't people trying to 22 fulfil this function but that overall, this function of 23 joining together individual experiences and to see that 24 there's something systemic behind it was not happening 25 sufficiently? Page 39
1 issue to be triggered by one individual, isn't it? 2 A. Yes, it is. 3 Q. It depends perhaps on the nature of the issue that is 4 being raised? 5 A. Yes. 6 Q. So in some circumstances it might be that the systemic 7 issue requires multiple individuals to tell you 8 something is happening for it to become a systemic 9 issue but in other circumstances it may be sufficient 10 for an individual to raise that systemic issue with you? 11 A. Yes. 12 Q. And I suppose the skill in your job is working out when 13 that threshold is met? 14 A. Yes, and that's something our framework is trying to do. 15 And a little bit like I have articulated in this, you 16 know every story is important because it adds to you 17 know to the widening systemic. So even if it is -- 18 I don't want to trivialise anybody's story, that's what 19 I'm saying. So for me every story that comes my way is 20 important. 21 Q. Do you think -- is it your understanding that the reason 22 why a role was needed and required legislation to be 23 passed and everything so that someone would do that 24 apparently very important role, was that nobody was 25 doing that within healthcare before, or there was Page 38	1 A. That's correct. 2 Q. There's an aspect of the evidence that you've given so 3 far that I'd like to explore a bit further with you 4 which is to do with the way in which people articulate 5 that they have a problem with healthcare. You've 6 identified, very helpfully, that that can vary greatly 7 from individual to individual for innumerable reasons 8 I'm sure, based on their own personal circumstances. 9 One other aspect in this -- we're looking, in this 10 Inquiry, at complaints systems and outcomes and we are 11 interested in particular the extent to which patients 12 are afforded ample opportunity to raise what one might 13 call concerns or issues and the extent to which formal 14 complaint systems may be difficult to engage with for 15 various reasons. Some of the evidence that you've given 16 has talked about the start of something being 17 a complaint but if people feel unable or are unable to 18 access a complaint system, no matter how formal or 19 informal, that process never starts, does it? 20 A. No. 21 Q. And is it therefore important that when someone has 22 an issue, a problem with their healthcare and that their 23 opinion, as you've said, should be respected and should 24 not be ignored and should become data, as you said in 25 your statement, that the opportunity for someone to Page 40

1 express that they feel that way should be open to them? 2 A. Absolutely. 3 Q. And is it a phenomenon, either as a result of your 4 researches over the last year what patients have told 5 you or your wider experience, that complaints systems of 6 whatever nature are difficult to access or, perhaps more 7 importantly, that patients feel are difficult to access? 8 A. I think it's a number of things. I think there are time 9 pressures on people who are looking at complaints, you 10 know, because if patients are being told: we'll get back 11 to you in nine months, one, that's not very reassuring. 12 But two, it tells me that there's a pressure up the 13 system, you know, if you have a backlog of complaints 14 that you're waiting nine months to respond to. So 15 I think there are many, many issues that are highlighted 16 from that, and so I think -- sorry, can you -- I have 17 gone off. 18 Q. I was interested in exploring the extent to which you 19 consider it important that complaints systems, however 20 formal or informal, be accessible to patients given the 21 fact that they may, even if perhaps to a health board or 22 to a GP practice they seem accessible, so there's a form 23 there you can fill out, to a patient there is still the 24 considerable hurdle in engaging with that? 25 A. Yes. Page 41	1 A. Yes, I think, you know, patients are inherently loyal to 2 the NHS because, you know, they believe in it. But when 3 a system has let them down I think they still will do it 4 with reservation and disappointment because -- 5 Q. There is a certain Britishness in that as well, I think. 6 Reticence to complain about anything, perhaps the NHS 7 most of all, is a phenomenon that people tend to 8 recognise? 9 A. Yes. 10 Q. Would you say, therefore, from your patient-centred, 11 patient safety perspective, that it's important that 12 there are multiple systems in place to try to detect 13 when things are going wrong that don't rely solely on 14 patients speaking up and in many ways that's part of 15 your role? 16 A. Yes. 17 Q. Because part of your role, from the passage that I have 18 just read out, involves very much collecting all of the 19 data from patients and putting it together to try to 20 work out whether there's something systemic going on? 21 A. Yes. 22 Q. And what you are doing in that exercise one might use 23 the word is "triangulating" the data? 24 A. Yes. 25 Q. To try to see the bigger picture? Page 43
1 Q. Is that a phenomenon that you recognise? 2 A. Yes. Yes. 3 Q. Because in essence if you think about the concept of 4 complaining, to take what we're interested in within 5 a neurosurgical setting, all of the patients -- if not 6 all, very nearly all of the patients are very seriously 7 unwell when they're engaging with the healthcare system 8 in neurosurgery; is that correct? 9 A. Yes. 10 Q. And they are engaging in a process -- we've heard some 11 evidence about this already -- where they are very much 12 giving themselves over physically, psychologically, 13 emotionally to a system and placing their faith in that 14 system? 15 A. Yes. 16 Q. And they trust that that system will handle them with 17 care, is that a reasonable assumption? 18 A. Yes. 19 Q. And that when things do not go right it's often the case 20 that they don't really know why that has happened? 21 A. Yes. 22 Q. And that that system in which they put their trust must 23 seem like a daunting system to complain about. Do you 24 think that's fair? Is that commensurate with your 25 experience? Page 42	1 A. Yes. 2 Q. And it's essential that you do that? 3 A. Yes. 4 Q. Because otherwise it might just seem to the individual 5 that this is just a problem that's affected me? 6 A. Yes. 7 MR DAWSON: Thank you. Sir, that would be an appropriate 8 moment for a break if it would be convenient. 9 THE CHAIR: Thank you. Mrs Titchener, we're going to have 10 a short break for approximately 15 minutes. Ms Miller 11 will take you back to the witness room. I'm just going 12 to mention something I always mention to any witness in 13 your situation, please don't discuss your evidence 14 during the break. We will see you again in a quarter of 15 an hour's time. 16 (11.10 am) 17 (A short break) 18 (11.26 am) 19 THE CHAIR: Thank you, Mrs Titchener, we're ready to resume. 20 Mr Dawson, when you're ready. 21 MR DAWSON: Thank you. Can I just ask you some questions, 22 Mrs Titchener, obviously your title includes the concept 23 "patient safety" and you've helpfully provided in your 24 statement some comments on how you might go about 25 interpreting that. So if we go to the statement, Page 44

1 please, at paragraph 3.5. 2 3.4 you say: 3 "On the specific question of care, experience and 4 satisfaction, I would draw a practical distinction." 5 And you set out your definitions, if you like, of 6 these different things. You say: 7 "Patient care being the clinical and organisational 8 quality of what is delivered which falls within my remit 9 where it carries safety implications. A system that 10 routinely fails to assess a patient's risk before 11 a clinical decision is made is a patient safety issue, 12 not simply a care quality concern." 13 Then you say: 14 "Patient experience [at paragraph 3.6] is directly 15 relevant to my remit where it signals underlying safety 16 risk. When patients consistently report not being 17 listened to, not being informed of risks, or [then, over 18 the page] feeling unable to raise concerns, that is not 19 merely a satisfaction issue it is evidence of a system 20 that may not be safe. The Act explicitly requires me to 21 promote the importance of the patient voice in relation 22 to safety, which means experience is a legitimate and 23 important source of evidence for my work. 24 "Patient satisfaction in the narrower sense, for 25 example, whether someone found a ward comfortable or Page 45	1 Q. Okay. And I think you say in the statement that 2 "patient safety" is not defined in the Act? 3 A. No. 4 Q. One might find that odd but I think you say that your 5 interpretation at least that was deliberate to allow to 6 do it; is that right? 7 A. Yes, exactly. 8 Q. And obviously this is part of your thinking as to how 9 you've done that? 10 A. Yes. 11 Q. Could I ask you some questions about your powers. You 12 are able to undertake formal investigations? 13 A. Yes. 14 Q. Is that correct? 15 A. Yes. 16 Q. I think that falls -- if we go back to the Act, please, 17 although I'm quite keen, as I said, to avoid it if we 18 can. It's ELJ-00559. Looking at page 4 at the bottom, 19 section 8 deals with the initiation of formal 20 investigations. It sets out a process whereby there are 21 various steps that need to be taken including you coming 22 up with Terms of Reference and then, over the page, 23 there are various requirements to make them publicly 24 available, information to be supplied and then, under 25 section 9, there's a definition of what the Terms of Page 47
1 a clinician approachable sits outside my primary focus. 2 My statutory purpose is systemic safety improvement." 3 So, you've obviously had a think about these 4 different things and what "patient safety" in the title 5 means. It seems from that, as far as I could interpret 6 it, that you've taken probably quite a wide definition 7 of "patient safety" including a number of aspects which 8 might not technically be deemed to fall within it but 9 which ultimately affect patient safety; would that be 10 a correct interpretation? 11 A. That's correct. 12 Q. Because again, oddly, we have toyed and struggled with 13 aspects of our Terms of Reference where they talk about 14 patient safety, as they do in places and "patient care" 15 for example and they also talk about "treatment" and 16 we've certainly taken the view that we're not looking 17 just at treatment, in the sense of surgery or whatever, 18 but looking at a broader patient experience of that. So 19 it's not just the surgery itself but it's the experience 20 of the care that was received by the patient. 21 Is that broadly comparable with the sort of approach 22 that you've taken and anything that can impact on 23 patient safety you're prepared to look at? 24 A. Yes, it's that lived experience that only they have to 25 do with their care. Page 46	1 Reference need to look like. Section 10 has provisions 2 relating to an investigation report. 3 Are you able to investigate things other than by way 4 of a formal investigation? 5 A. So we would call that an informal, yes. So that's the 6 approach that I have been taking so far where -- that if 7 somebody is putting something forward to me that I feel 8 is a safety issue, I will approach the boards on that 9 and ask the -- you know, say: I have heard this from the 10 patient with the patient's permission. 11 Q. The reason I ask that, Mrs Titchener, is it occurred to 12 us that those provisions are potentially quite 13 cumbersome in terms of the number of procedural steps 14 that need to be taken for a formal investigation to 15 happen? 16 A. Yes. 17 Q. Which might not be appropriate, for example, if dealing 18 with what you described earlier is a "now" issue? 19 A. Yes, I agree and that's where we're taking legal counsel 20 and we've only just got that in place to say: if we're 21 not taking a formal process, what are we able to do 22 prior to that? So at the minute with all the health 23 boards we are doing, an understanding to say: if I am 24 concerned about something what do you want my process to 25 be? And, you know, that's around me speaking to the Page 48

1 Chair and then what does that look like? So that -- 2 because in the early days, they were like: who is this 3 and what's she asking and why's she writing? And maybe 4 five emails in, I was getting the answer that I was 5 looking for. So I think you have to remember we're 6 a very new office and so people are trying to work out, 7 well, who is she and what powers does she have and why 8 is she asking this question. 9 Q. We heard some evidence yesterday about an issue that 10 exists in the health service about people not reading 11 emails, so at least they read them I suppose? 12 A. Yes. Well, I do say they have to respond within 13 24 hours, so hopefully they do. 14 Q. I see, you have some other powers, if we scroll on 15 further, that -- under paragraph 12 you can require 16 information as part of a formal investigation, I think? 17 A. Yes. 18 Q. And under -- that can be from, I think, healthcare 19 providers including health boards? 20 A. Yes. 21 Q. And under paragraph 14(4) there is an ultimate sanction, 22 I think, that you can make an application to the Court 23 of Session for an enforcement order which can treat the 24 failure to comply with your request for information as 25 a contempt of court? Page 49	1 One of the core functions that you have is to 2 promote improvement, I think? 3 A. Yes. 4 Q. But you say there that you don't consider your role to 5 be an inspector. I just wanted to tease out from you 6 what it was that you meant -- where the boundary lay 7 there? 8 A. Well, that's Healthcare Improvement Scotland role. So 9 therefore the terminology that the Act has used is 10 "investigation". So that doesn't mean that part of that 11 investigation doesn't go and walk the corridors and, in 12 no uncertain terms, does inspect. But the role is that 13 would be to inform the investigation as opposed to 14 a formal inspection. 15 Q. Do you have, or do you intend to have -- I think you 16 mentioned a moment ago memoranda of understanding, 17 common phenomenon is Scottish public services, that you 18 were intending on having that to clarify your role and 19 access rights and all that sort of thing with health 20 boards. Do you have, or do you intend to have, that 21 with other bodies, for example Healthcare Improvement 22 Scotland? 23 A. Yes, so Healthcare Improvement Scotland we're just about 24 to sign off on our memorandum of understanding and also 25 with the Ombudsman because again, both of those bodies Page 51
1 A. Yes. 2 Q. I take it from the broad description you've given of 3 what you've been doing so far that you haven't launched 4 any formal investigations yet? 5 A. No, almost a couple of times but again, because we're 6 waiting to make sure that what we are -- the process 7 that we're doing matches what the Act says, we haven't 8 triggered that. 9 Q. But there have been a number of informal things that 10 you've done, I think? 11 A. There have been multiple informal things. 12 Q. Yes, thank you. Sorry to jump around a bit, but could 13 we go back to the statement at paragraph 4.12. You say 14 there: 15 " ... the principal distinction is that the Patient 16 Safety Commissioner for Scotland is not a provider, 17 employer, inspector, educator, professional regulator or 18 government department. The Commissioner's role is to 19 bring an independent, patient-centred focus to patient 20 safety across the system, to identify themes and risks, 21 and to promote improvement. Any overlap with the bodies 22 listed above [which are health boards, etc] is therefore 23 limited and complementary, rather than constituting 24 duplication of their statutory or operational 25 responsibilities." Page 50	1 will be able to see key things themes and things that 2 they're concerned about. 3 Q. So is that an attempt -- it probably does a number of 4 things. Does it clarify the roles of each body? 5 A. It does. 6 Q. And does it attempt to, perhaps the word I used earlier 7 was "triangulate" your various different data sources, 8 if you like, to try to promote healthcare improvement in 9 patient safety? 10 A. I agree. It's in a spirit of collaboration to say: we 11 all need to be talking together because no individual 12 organisation can do this on their own. We're all in 13 this together to make care in Scotland safer, therefore 14 how do we work together without walking on each other's 15 toes. 16 Q. And does that collaboration extend, in a practical 17 sense, to you being able to be involved in the 18 inspections that Healthcare Improvement Scotland would 19 undertake? 20 A. No. 21 Q. No, but it would involve what sort of steps to try to 22 promote that collaboration? 23 A. So, the sharing of information, you know, if we are 24 concerned about something that we could raise that with 25 them and say: are you concerned? You know, have you had Page 52

1 any contact with this? So we're just trying to, a bit 2 like you said, triangulate that information. 3 Q. I see. I see, so for example hypothetically, you 4 obviously would have a more patient-facing role, 5 patients would be telling you things, and then you 6 wouldn't be able to do an inspection but it could be 7 that that information might be helpful to an inspection 8 being contemplated by Healthcare Improvement Scotland? 9 A. Exactly. 10 Q. And what -- in fact, this organisation has changed. 11 There was an organisation called NHS Education for 12 Scotland which has become part of a different 13 organisation called Public Services Delivery Scotland. 14 I happen to be an expert on that because I have a 15 witness from that organisation this afternoon. However, 16 they are involved in training of resident doctors and 17 other health professionals. Is that a body into whose 18 operations you would wish to have some information 19 sharing or is it a body with whom you plan to have 20 a memorandum of understanding? 21 A. Not at the minute, we haven't considered that. 22 Q. Because again, through the evidence we've heard in this 23 Inquiry and our remit, one of the things that we're keen 24 to look at in our -- as you are aware, our ambition to try to 25 find answers to things and to promote patient safety, is Page 53	1 through the complicated provisions of the Act which have 2 prescribed, and continue to prescribe on you, that you 3 require to take various steps effectively for your 4 office to be able to carry out its important functions 5 but as I understand it, the Act requires you -- this is 6 an ongoing obligation because I think although you've 7 done many of these things, there's a need to continue 8 refreshing documentation and things, but I think you 9 need to set up, as I understand it a set, of principles, 10 a charter and a strategic plan; is that correct? 11 A. Yes, that's -- you have those. 12 Q. Yes. So all three of those have now been done? 13 A. Yes. 14 Q. And could we have a look, please, at PSC-00005. And 15 these are the principles that I think you've published 16 in accordance with your statutory obligation. How were 17 these compiled? 18 A. So these were my first thought and then they went before 19 the advisory group which, by statutory law, has to have 20 the 50% patient representative and 50% professional and 21 then it had to go through the corporate body before it 22 could be agreed. 23 Q. Just on the subject of the advisory group which was 24 something I was going to touch on. As you say there is 25 a statutory requirement for it to have a certain make-up Page 55
1 that we are looking at the way in which doctors are 2 trained. 3 A. Yes. 4 Q. And it may well be that there are various organisations 5 that contribute to that complicated exercise but some 6 representation of patient concerns and patient voice in 7 that process, I think would you agree, would be a useful 8 contribution? 9 A. Yes. Yes, I have had a discussion with the GMC around 10 doctor training, around speaking up actually to say, you 11 know, just because you're a new doctor and you have your 12 surgeon, are you coaching them into how you could speak 13 up because I think it needs to be part of the training. 14 So I have brought that up at a recent education meeting 15 with the GMC. So I feel that's a very important thing 16 around doctors' training. 17 Q. Was that an area in which you felt there was weakness or 18 was it just an observation you felt there was -- 19 A. Well, it was because of this current -- 20 you know, Mr Eljamel, that I was wanting to say: well, 21 how do we, with doctors' training, how do we ensure that 22 junior doctors feel able to speak up even if the person 23 that they're speaking up about is somebody that's a much 24 higher pay grade than they are? 25 Q. Excellent. Thank you very much. I'm not going to go Page 54	1 and that is a body which is there to help you discharge 2 your functions and is, I think, one of the mechanisms by 3 which, for example, the patient voice is heard by you as 4 well as many, many others but is a more formal role 5 which includes patient representation. How did you go 6 about finding people that would be part of that group 7 and what were the characteristics that were thought to 8 be useful? 9 A. So that was -- again, I was new to Scotland so 10 I literally didn't know anybody. So that was around me 11 getting out, meeting people, speaking to patients and 12 I think -- and then deciding who would be helpful 13 because of their -- so if it was somebody professional, 14 it was because of the experience that they had had and 15 what they could bring to the table and add beyond my 16 experience. And then for the patients I wanted to make 17 sure there was a good mix of different stories, and that 18 they were not just going to be advocating for their own 19 corner but that they literally wanted to represent, you 20 know, patients from Scotland. 21 Q. I see and so the patient representatives, are they 22 people that are sort of found by you or is there 23 an application process? 24 A. No, there is not an application process. We would write 25 to people and say -- and actually we're just about to Page 56

1 add a few more people. We started with six because that 2 was the limit of my knowledge at that time and we're 3 growing that to, I think, about ten. 4 Q. And if I could have a look then back at the principles 5 document we were looking at. You have set this out in 6 the form of looking at -- the various principles that 7 are included in it are first of all, that you will 8 "listen, include and act on patient voice". Second, 9 "make safety a shared, system-wide responsibility", 10 third, "focus on systemic learning and improvement", 11 fourth, "champion openness, transparency and 12 accountability". Then over the page, "5, use evidence, 13 data and insight to drive change", "6, act with 14 independence, integrity and public interest". 15 Now, one of the things that you set out in this in 16 the principles is not only what the principles are, but 17 you have set out why you've included them. Why did you 18 think it important to say why? 19 A. Well, because otherwise they're just random -- I thought 20 it was important -- remember I'm a public-facing office 21 and I'm here to serve patients. So I wanted to make 22 sure that patients had understood why I chose those 23 principles. 24 Q. Yes, and it's important for public authorities and 25 public-facing bodies to explain why they do things? Page 57	1 to speak up. 2 "Communicate inclusively and accessibly." 3 And then, under the further bullet points: 4 "The charter will be publicly available. 5 "A safety management system will be used to log and 6 manage concerns. 7 "Progress will be reported through annual reporting. 8 "[And] the Charter will be reviewed regularly in 9 consultation with stakeholders." 10 That last section is titled "Accountability" because 11 it's important public facing individuals are accountable 12 for their actions, isn't it? 13 A. Yes. 14 Q. As far as the expectations of the bodies are concerned, 15 how -- it's a succinct list, but how was that compiled? 16 A. Again, it was just my process of listening to patients 17 and making sure, from what I had heard, that we -- you 18 know, it feels very sad that you have to articulate this 19 but this was what I really felt I needed to be saying to 20 people: this is how you should be treating patients. 21 Q. You're one step ahead, Mrs Titchener, because that was 22 precisely the point I wanted to raise with you which was 23 although this is a very helpful, succinct list, it's not 24 exactly reinventing the wheel. One might have thought 25 that these are principles that healthcare providers Page 59
1 A. Yes. 2 Q. Thank you. And you've also -- you also have a charter 3 which is PSC-00006 if we could have a quick look at 4 that, please. My understanding was that this set out, 5 in accordance with the statute, slightly different 6 things. One is it explains what patients and families 7 can expect when safety concerns arise? 8 A. Yes. 9 Q. And also separately what you expected from healthcare 10 providers and product public bodies with regard to 11 public safety. So the first part is seen there and if 12 we scroll on further, I think the last part is on the 13 last page, could we go to that, page 4. Thank you. 14 There you set out the expectations of the healthcare 15 providers and public bodies: 16 "Providers and public bodies are expected to. 17 "listen and respond to patient and family safety 18 concerns. 19 "Be open and transparent about incidents and 20 learning. 21 "Act promptly to reduce risks and prevent 22 recurrence. 23 "Cooperate with the Commissioner and provide 24 relevant information. 25 "Foster a culture where staff and patients feel safe Page 58	1 would have at the forefront of their operations as they 2 are really the cornerstones of really having any regard 3 to patient safety, one might say? 4 A. Yes. Yes. 5 Q. So these are not innovations? 6 A. No. 7 Q. These are simply, perhaps in your office given where you 8 are, really just a starting point? 9 A. Yes. 10 Q. Which you would expect everyone to be doing anyway? 11 A. Yes, and we're taking it one step further, in fact, 12 because we were asked by a patient if we could put 13 together a framework for which boards would interact 14 with patients. So we've now got a working party, all of 15 patients and it will be their words, we're just helping 16 them to actually put together a framework for us to give 17 to boards to say: when you're interacting with patients, 18 here's how we want to be treated. 19 Q. Okay, thank you. We talked earlier about the 20 possibility that systems that may exist for raising 21 concerns or complaints may be difficult to access or 22 penetrate and it may be that those with legitimate 23 issues or concerns might feel reluctant to do so. The 24 same might potentially be the case with your office in 25 that people might not know you're there or how to access Page 60

1 you or feel reluctant to step forward. What steps do 2 you take actively to seek out patient experience so as 3 to inform your work? 4 A. Yes. So we now have our website up and running so 5 patients can access that and have been accessing that to 6 get through to the enquiry line. Obviously, we're -- 7 we've got our Facebook page now, we've got a LinkedIn 8 page, but more than that, I'm trying to make sure -- and 9 I'm doing a reasonable job but trying to do better -- at 10 making sure I'm activating all patient voices and 11 patient groups within society. And earlier on I talked 12 to you about doing town halls, so going out into the 13 rural areas. And rather than doing it in a public forum 14 people might still feel nervous to speak out, we have 15 given time-slots to say where you have a half an hour 16 with the commissioner or somebody in her team. Because 17 again, that's trying to address, you know, people who 18 may not be as articulate and not want to talk in 19 a public forum. So we're trying to do things like that. 20 We've reached out to patient advocacy groups, you 21 know, we've reached out to the homeless society. We 22 also have somebody from the Royal Institute for the 23 Blind because we're making sure our website is 24 accessible for them, they actually sit on our advisory 25 group. So we're doing our best to try and reach the Page 61	1 do? 2 A. Yes. 3 Q. One hears often about various agencies stating that the 4 way they go about things is "trauma-informed", what do 5 you understand that to mean? 6 A. Well, it should really mean that their interactions 7 should be done in a sensitive way that doesn't bring 8 back all the trauma that happened previously. So it 9 should be aware of how to articulate and how to interact 10 with that person that doesn't diminish what went on 11 before but also doesn't reinforce it and start it all 12 happening again. 13 Q. I see, so it's a sort of prerequisite to 14 a trauma-informed approach that there should be, in the 15 person that one is interacting with, some previous event 16 that has caused that trauma? 17 A. Yes. 18 Q. What one is seeking to do is to try not to, I think you 19 said to cause a recurrence -- but to recognise that that 20 trauma will have an effect on that person? 21 A. Yes. 22 Q. I wonder if you, either through your work so far or your 23 more general experience and knowledge of patients, have 24 experience of issues that patients experience within the 25 healthcare setting of document management? Do you have Page 63
1 mixed population that Scotland is. 2 Q. Thank you. 3 THE CHAIR: Sorry, Mr Dawson, just to pick up on one point 4 and I think I know the answer but I'll ask it anyway. 5 In terms of the patient contribution to putting together 6 these constitutional documents that you talked about 7 from these six, possibly moving on to ten, and 8 referencing the specific example that you did just now 9 about a patient who had advocated for a framework for 10 you to connect with health boards, may I take it that 11 the insights that have been shared with you by reaching 12 out to patients in this way has been of benefit to you 13 in helping to put together this framework? 14 A. Extraordinarily so. The patients are amazing people and 15 they have great insight into what's going on, so I think 16 I have a great job being able to interact with them and 17 help them move things forward. 18 THE CHAIR: So there might be some lessons to be learned 19 from that as well? 20 A. Absolutely. 21 THE CHAIR: Thank you. 22 MR DAWSON: Is the phrase "trauma-informed" something you're 23 familiar with? 24 A. Yes. 25 Q. Does it feature in your approach to your work or will it Page 62	1 issues -- do you have experience of patients having 2 issues with those sorts of things? 3 A. Yes. 4 Q. Access to notes and that sort of thing? 5 A. Yes. 6 Q. Please say if I'm going beyond the remit but 7 I'm interested to explore with you, given your 8 experience, how important a part it is of a patient's 9 experience of healthcare that it is properly documented 10 and that there are clear records that they can then 11 access themselves about what has happened to them? 12 A. I think it is very important and I think we have to look 13 at a system where, on my phone app, I can see exactly 14 what the doctor wrote in my notes and reassure that 15 that's -- that that's accurate. Because a lot of our 16 interactions when they've asked for, you know, freedom 17 of information and they've got their notes through, 18 they're just like: well, hang on, that doesn't match the 19 conversation that we had or they haven't mentioned this. 20 So I think -- and I have been a nurse a long, long time 21 and, you know, if you haven't written it, you didn't do 22 it. And maybe that's not what they say these days but 23 I would still say that. So I think documentation for 24 patients particularly as well as for patient safety, is 25 very important. Page 64

1 Q. Yes, nurses saying if they haven't written it they 2 didn't do it can come back to bite them sometimes in my 3 experience but the point that you made about it being on 4 a phone app is perhaps interesting because is there 5 a distinction to be made between that solution -- 6 I'm sure there are all sorts of technological issues 7 with it but that idea and the alternative which you have 8 proposed, which is somebody going through a lengthy 9 process to be able to access their records finding, as 10 you hypothesise, as some patients say they have, that 11 what is written does not reflect the reality of what 12 happened. 13 But the problem with that is that it's not 14 instantaneous. So there is a process to be gone 15 through, it may be many years before the patient asked 16 to see the notes, they may not be complete. Does the 17 phone app concept incorporate within it something more 18 of an instantaneous ability to access notes, to try to 19 address some of those problems? 20 A. I definitely think that that's how we have to move. 21 I think technology is moving at speed and health 22 technology does not move at speed and if you see 23 a doctor in one city, your notes don't transfer to the 24 next appointment. So that in itself is a risk. 25 Q. Yes, and in terms of moving then out of healthcare Page 65	1 investigate or look into in order to try to promote 2 patient safety. So for example would it be at the 3 lowest level or at the hospital level or at the 4 government policy level and do you feel that all levels 5 of the healthcare system would be open to you to try to 6 interact with and influence? 7 A. So what are you asking me about the interaction? 8 Q. I'm focusing more or less on what the interaction will 9 be and more on what level of the system you feel you 10 would be empowered or intend to interact with. Because 11 obviously healthcare is provided from the very first 12 time you walk through the door all the way up to the 13 government effectively. So all of those things one 14 might say require the patient voice to be heard in order 15 that patient safety is prioritised. But where would you 16 feel -- at the moment -- it may be too early to say -- 17 if you can say, that your influence would be best 18 expressed or your investigations might be best 19 addressed? 20 A. Well, at the minute the process is that in the first 21 instance we talk to the chief executives of the boards 22 for every, you know, question or query that we have and 23 that is that process. 24 Q. Okay, thank you. So I'd just like to ask you a couple 25 of questions about how the role fits in with some other Page 67
1 generally, more into what your own practice is going to 2 be, and it may have been formerly, one of the issues 3 which does exist, no doubt for you as well as in 4 healthcare relating to recording information, is the 5 importance of confidentiality. It is important, as 6 you've recognised and you have committed to, you will 7 gather patient experience, hear the patient voice and 8 seek to advocate on behalf of the patients, but how do 9 you intend to gather and retain data, as you've called 10 it, information from patients? What are your thoughts, 11 what are your systems going to be for that? 12 A. Yes. We're just about to start a case management system 13 which is -- you know, it's a confidential data base that 14 we will put all the patient interactions in. So that's 15 how we're going to be dealing with that information. 16 Q. And will patients -- sorry, will patients approach you 17 not in that capacity but approaching you as somebody who 18 wants to raise an issue, will they be aware of what your 19 intentions are with regard to what will be retained of 20 what's discussed, if I can put it that way? 21 A. Yes. 22 Q. I wonder whether, in your investigations so far and in 23 your setting up of your office, you have any sort of 24 feel at this stage as to the level of the healthcare 25 system which you feel you may need to interrogate or Page 66	1 systems in the UK because obviously the Cumberlege 2 Review gave rise to patient safety commissioner, for 3 example, for England being put in place. I think you 4 say in your statement although it's not an obligation 5 for you to have interaction with the patient safety 6 commissioner in England, you have decided to do so? 7 A. Yes. 8 Q. I think you say you maybe sit on advisory board for that 9 role? 10 A. Yes, I do. 11 Q. And is that a part-time role, the English role? 12 A. No, it's a full-time -- 13 Q. It's full-time role, right. So it really is pretty much 14 the equivalent of the role that you hold, but just 15 a different jurisdiction? 16 A. It's a different jurisdiction, yes. 17 Q. And it's not restricted in any way, as I asked you 18 earlier, as to whether it's restricted just to do with 19 medicines and medical devices? 20 A. It is, it is only. And it actually not sits with MHRA, 21 so not a truly independent role. 22 THE CHAIR: Just so everybody understands, what's MHRA? 23 A. I knew you were going to ask me that. It's the 24 medical -- it's the regulatory body for medicines and 25 medical devices. Page 68

1 THE CHAIR: Thank you. 2 MR DAWSON: So the role is more limited in the scope, it 3 deals with just the things that were concerns in the 4 Cumberlege Review? 5 A. Yes. 6 Q. Whereas your role is far more wide-reaching? 7 A. Yes, but the population is 70 million. 8 Q. Absolutely. One might say that one could have a bigger 9 office to deal with more things but that is 10 a difference. The other difference is that there isn't 11 this ingrained independence -- 12 A. Yes. 13 Q. -- that you have. You report to the parliament, as you 14 said -- 15 A. Yes. 16 Q. -- but that now sits within -- effectively MHRA would be 17 a government agency or something like that? 18 A. Yes. 19 Q. Thank you. We asked you -- although you've helpfully 20 provided some answer although it necessarily logically 21 pre-dates your taking the role, we asked you some 22 questions about why it had appeared to have taken so 23 long for your role to be filled and you have given us 24 what helpful answers you can about that. The Cumberlege 25 report came out in 2020, is that right? Page 69	1 interest in patient safety in Scotland? 2 A. I don't think that's the case. I think probably people 3 who know Scotland know that perhaps it would be -- it 4 could be a bigger role than they might want to do. 5 Q. Yes. I understand, yes. You've had some interaction 6 with some of the patients within the Eljamel group, as 7 I think we've touched on? 8 A. Yes. 9 Q. And in your statement I think you candidly tell us that 10 there was -- you had a degree of reticence and 11 reluctance in discussing matters with them while there 12 was an ongoing public inquiry? 13 A. That's correct. 14 Q. One of the aspects of that that you might not be aware 15 of is that this Public Inquiry is looking predominantly 16 at healthcare systems within the NHS, rather than 17 looking at systems within private care, although 18 Mr Eljamel did have a private practice and there are 19 large numbers of private patients who also have suffered 20 adverse outcomes and claim -- or suspect things have 21 gone wrong within those systems. 22 Given that that is not within the remit, would that 23 be something that you would feel more comfortable about 24 interacting with them to do with? The reason I ask is 25 I know -- I didn't set the Terms of Reference for this Page 71
1 A. Yes. 2 Q. And I think the English role was filled in 2022; is that 3 correct? 4 A. Yes, that's correct. 5 Q. And there seemed to be some significant difficulty in 6 filling your role, is that right? 7 A. Well, I know that I was recruited on the third round, 8 so -- but as I wasn't in Scotland so I don't know what 9 that difficulty was. 10 Q. Yes, I understand the limitations but does it -- do you 11 know, for example, whether in the first instance they 12 were just looking within Scotland and then they went 13 more broadly and that's why you became a potential 14 candidate, is that what they did? 15 A. I honestly don't know, I'm sorry. 16 Q. Right, it does seem perhaps, on one view, quite odd that 17 there wouldn't be a number of people within Scotland who 18 would be keen to put themselves forward for the role and 19 that there would be, one would imagine, a number of 20 people with a qualification for it, would you agree? 21 A. Yes. 22 Q. Would it be reasonable do you think, based on the fact 23 that it took so long to fill it and your experiences, 24 some of which you've helpfully relayed to us to date, 25 that that might tend to indicate there isn't a great Page 70	1 Inquiry but I know there are private patients who are, 2 understandably I think, upset about the fact that this 3 Inquiry won't cover the full ambit of the care that 4 Mr Eljamel provided and I think they might be interested 5 in trying to find other avenues for exploration, not of 6 course in a historic sense, but in the sense of trying 7 to have an outlet for what they've learned and their 8 patient safety concerns. Is that something, given that 9 I have clarified the remit, that you would feel more 10 comfortable in becoming involved with? 11 A. It is something that I could consider. But again, given 12 the remit of the historical -- within the Act it's -- 13 and obviously it's a longer time than -- you know, 14 I know you're also doing it and it was ten years ago or 15 whatever. So I think it's something that -- it isn't 16 something that I have thought about, so thank you for 17 bringing it to my attention. So it will be something 18 that we can definitely look at. 19 Q. Absolutely, thank you for that. Just again, to go back 20 to -- we discussed this point before but in terms of the 21 historic, you focus very much, when we looked at that 22 section of the Act, I think on the fact that you don't 23 have any powers and your role is not about giving 24 redress for past grievances but that doesn't prevent you 25 looking at past events. In fact, you told us everything Page 72

1 is a past event you look at in order to help healthcare 2 in the future; is that correct? 3 A. Yes. 4 Q. And I suppose the point you're making about how long ago 5 things may have happened is to do with the extent to 6 which something more historic is, logically, less likely 7 to have an impact on where we are now in the healthcare 8 system? 9 A. Yes. 10 Q. Although it's not impossible at all? 11 A. Not impossible. 12 Q. And one can often learn lessons from the distant past 13 that can resonate in the present -- 14 A. Yes. 15 Q. -- do you agree? 16 A. Yes. 17 Q. Thank you. Excuse me just one second. Could I just go 18 to the conclusions please in your statement, 19 paragraph 15.4. You help us out with some conclusions 20 based on your work so far. You say there from this 21 work, which you say above is based on your general 22 experience and engagement with patients, families and 23 stakeholders, you tell us that you: 24 "... have observed that the promotion of patient 25 safety is closely linked to: Page 73	1 A. Yes. 2 Q. And you go on to say, at paragraph 15.5: 3 "I have also observed that patients and families may 4 experience difficulty in navigating systems when 5 concerns arise, particularly where those concerns relate 6 to serious harm." 7 Systems which are not accessible undermine patient 8 safety? 9 A. Yes. 10 Q. And you say, at 15.6: 11 "These reflections are general in nature and not 12 specific to any individual clinician, organisation or 13 specialty. 14 "In my time in post, I have reflected on the 15 importance of ensuring that systems are sufficiently 16 robust to identify and respond to patient safety 17 concerns at an early stage." 18 You say: 19 "Ongoing attention to transparency, patient 20 involvement and system learning is, in my view, 21 essential in supporting confidential that such issues 22 are unlikely recur. 23 "In my role, I have reflected on the importance of 24 ensuring that systems for identifying and responding to 25 patient safety concerns are sufficiently robust and Page 75
1 "The extent to which patient voices are heard and 2 acted upon. 3 "The effectiveness of systems raising and responding 4 to concerns; and. 5 "The transparency of communication between 6 healthcare providers and patients." 7 So, systems to allow patients to raise concerns need 8 to be effective to promote patient safety? 9 A. That's correct. 10 Q. And they need to take action to -- they need to take 11 action to promote patient safety? 12 A. Yes. 13 Q. And to be able to understand and explain what action 14 they are taking and why? 15 A. Exactly. 16 Q. As you've explained why in some of your documents. If 17 these things are not done, patient safety will generally 18 be undermined? 19 A. Absolutely. 20 Q. And if there is a lack of transparency with patients, 21 that undermines patient safety too? 22 A. It does. 23 Q. And transparency with patients is not just a matter for 24 doctors but it's a matter for all healthcare providers, 25 isn't it? Page 74	1 effective. 2 "In particular, I consider it essential that patient 3 voices are heard, that concerns are acted upon at 4 an early stage, and that learning is identified and 5 applied consistently across the system. 6 "Continued attention to these areas is important in 7 supporting confidence in the safety and effectiveness of 8 healthcare services." 9 So in healthcare, patient voices must be heard? 10 A. Yes. 11 Q. And if they are not, that can undermine patient safety? 12 A. Yes. 13 Q. And learning needs to be identified and applied 14 consistently? 15 A. Yes. 16 Q. And if it is not, that can undermine patient safety? 17 A. Absolutely. 18 Q. And you also mention there the importance of patient 19 confidence in systems designed to promote patient 20 safety. Why is it important that patients are 21 confident in the systems that provide their healthcare? 22 A. Because if they're not confident then, you know, they're 23 not going to go, for a start. And that has happened 24 with some of the stories that I have been involved in, 25 they don't want to talk to a healthcare professional Page 76

1 because it went so wrong. So I think there has to be 2 that confidence. But also that confidence that when 3 they do speak up, that actually they're going to be 4 listened to it will be acted upon. That, for me, is 5 equally as important. 6 Q. So there are a number of aspects of that I'd just like 7 to clarify. In circumstances where a person has 8 an initial treatment that goes wrong and that experience 9 involves poor communication, then if they are in 10 a position where they need to go back and seek further 11 help because of what went wrong, they're less likely to 12 do so because of that initial experience; is that 13 correct? 14 A. Absolutely, that's correct. 15 Q. And that's because, I think, that their trust in the 16 system has been eroded? 17 A. Yes. 18 Q. And trust in the system is important as a general 19 concept but for some patients who have suffered physical 20 or psychological harm it's essential to their future 21 well-being? 22 A. Yes. 23 Q. Thank you. Mrs Titchener, those are the all the 24 questions I have for you. 25 A. Okay. Page 77	1 purposes of prevention of things happening to people in 2 the future and the improvement of systems. The patient 3 group was keen to know whether you had formally recorded 4 the information that they had given to you in order that 5 it might serve that purpose? 6 A. No, not at the minute. 7 Q. Does that mean you still have the information that 8 they've communicated in whatever form that was, or -- 9 A. So I still have the emails. 10 Q. Yes, so you have the information but it's not been 11 formally recorded in a way yet? 12 A. No, no. 13 Q. So it's still available for you for that purpose? 14 A. Yes. 15 Q. Thank you. There's nothing further, thank you very 16 much. 17 A. Thank you very much. 18 THE CHAIR: Thank you very much. Mrs Titchener, that, as 19 you will have gathered, is the end of your evidence. 20 Can I, before you leave the witness stand, thank you 21 very much for preparing for giving evidence today and 22 the statement that you provided, the 23 associated materials, but also for sharing your reflections 24 and insights today. We found it all very helpful and 25 all very interesting. With that and my thanks, you're Page 79
1 Q. Thank you very much. At this stage we'll have a short 2 break and offer an opportunity to our core participants 3 to propose some further questions for you. 4 A. Okay. 5 Q. But as I do with all witnesses at this stage, I'd just 6 like to invite you: is there anything further you'd like 7 to add? 8 A. No. 9 Q. Thank you. 10 A. Thank you. 11 MR DAWSON: So sir, a short break. 12 THE CHAIR: Yes, thank you Mrs Titchener. 13 Ms Miller will take you back to the witness room for 14 a short break while we deal with the next stage in our 15 procedure and we'll resume again as soon as. Thank you. 16 (12.11 pm) 17 (A short break) 18 (12.20 pm) 19 THE CHAIR: Thank you. Can we have the witness, please. 20 MR DAWSON: Sir, just one question, Mrs Titchener, possible 21 follow-ups. It's a question relating to the interaction 22 you had with the Eljamel groups, patient groups. As 23 I said earlier, there has been a consistent body of 24 evidence presented to us, which I think you recognised, 25 of people wishing that information be ingathered for the Page 78	1 free to go. 2 A. Thank you. Thank you very much. 3 MR DAWSON: Sir, there are various matters that need to be 4 attended to over the lunch break so I'd ask for 5 a slightly longer lunch than we normally have, maybe 6 2 o'clock? 7 THE CHAIR: 2 o'clock, yes, that's fine. Thank you 8 everybody. We'll resume again at 2 o'clock. 9 (12.22 pm) 10 (The short adjournment) 11 (2.09 pm) 12 THE CHAIR: Thank you, good afternoon. 13 MR DAWSON: Sir, the next witness is Emma Watson. 14 THE CHAIR: Thank you. 15 PROFESSOR EMMA WATSON (sworn) 16 Questions by COUNSEL TO THE INQUIRY 17 MR DAWSON: Thank you, sir. 18 Good afternoon. You are Emma Watson? 19 A. I am. 20 Q. It's Professor Watson, is it? 21 A. Professor Watson. 22 Q. You provided a witness statement then on behalf of NHS 23 Education for Scotland to the Inquiry, I think; is that 24 correct? 25 A. Yes, I did. Page 80

1 Q. Can I just say before I progress as I say to all the 2 witnesses if you can try to speak into those 3 microphones. It's quite tricky because they come from 4 both sides but just to make sure everybody can hear you 5 that would be brilliant. Thank you very much indeed. 6 Can I have up, please, on the screen, NES-00083. 7 This statement, on the front, bears to be dated 8 17 March 2026 but is that your statement? 9 A. Yes, it is. 10 Q. Can we go to page 32, please. Scroll down a little and 11 the statement has been signed by you, yes? 12 A. Yes. 13 Q. And the signature was actually dated 18 March, yes? 14 A. Yes. 15 Q. And as far as you're concerned are the contents of this 16 statement true? 17 A. Yes. 18 Q. Thank you. You are a medical doctor, I think? 19 A. Yes, I am. 20 Q. And the statement which you've given at page 1 tells us 21 that your qualifications are MBChB with an MSc in public 22 health and health services research and you also tell us 23 you're a fellow of both the Royal College of 24 Pathologists and the Royal College of Physicians under 25 medical microbiology. Page 81	1 doctor. So examples would be the foundation programme 2 which are the first two years post-qualification that 3 resident doctors in training undertake now. Halfway 4 through that point they get full registration with the 5 General Medical Council. Up until that point they're 6 provisionally registered. 7 Following the completion of foundation training, 8 doctors have various choice points they can make, they 9 can step away from training but we encourage them to 10 work in supported environments because they're very 11 early on in their career. Or they can choose to go into 12 a training programme. Those training programmes are 13 appointed competitively through a national process 14 across the whole of the UK. There are some programmes 15 that we recruit to solely in Scotland. 16 Q. Okay. 17 A. And then -- 18 Q. Could I just stop you there because I just want to take 19 that step by step. This material will be extremely 20 familiar to you but just so that we understand the 21 various different stages. So effectively one finishes 22 a medical degree and usually into the degree MBChB which 23 you've explained already and then after that I think 24 what you've told us is there would be a period that one 25 goes into of further training and that there could be Page 83
1 A. Yes. 2 Q. Is that all correct? 3 A. Yes. 4 Q. There's a few things I'd like to ask you about in that 5 regard which are of general interest to the Inquiry. 6 Did you practice as a doctor before taking up your 7 current role? 8 A. Yes. 9 Q. And what field? 10 A. In medical microbiology. 11 Q. Right, and when did you graduate with your MBChB? 12 A. 1992. 13 Q. And is that an undergraduate medical qualification? 14 A. Yes. 15 Q. And I'm using you as something of an illustration to 16 point out some aspects of medical education but one of 17 the expressions that we will hear in your evidence 18 I'm sure as it features in your statement is a "resident 19 doctor in training"? 20 A. Yes. 21 Q. Could you tell us what that is please? 22 A. So a resident doctor in training is a doctor from 23 post-graduation until they achieve their certificate of 24 completion of training or until they step out of 25 a training role and take up a role as an employed Page 82	1 a number of different paths that could be taken by 2 different people; is that correct? 3 A. Yeah. 4 Q. Is it the case that for all doctors one goes through 5 this foundation year -- two years, I think you said? 6 A. So all graduates from the UK must undertake foundation 7 programme to achieve GMC registration. 8 Q. Right, so when you graduate from university you're not 9 a registered doctor but after two years you can become 10 one? 11 A. At the end of the first year of foundation the majority 12 become fully registered with the GMC. 13 Q. Right, and when you talk about "foundation", what is it 14 that someone is doing over that period, what are the 15 ranges of activities one can be doing? 16 A. So they're consolidating the clinical learning they've 17 had in their undergraduate degree and they are becoming 18 used to the acute care environment and we would expect 19 that the doctor at the end of foundation to be able to 20 manage the acutely unwell patient within a supported 21 team environment. 22 Q. And then at the end of that, I think you mentioned the 23 possibility that one would enter training, is that 24 right? 25 A. So at the end of F2. Page 84

1 Q. F2. 2 A. So probably from about now I think specialty in core 3 training applications open in November. The current 4 foundation 2 doctors will be starting to think about 5 what is the next step for them in their training 6 pathway. 7 Q. And so this training period, is that where one becomes 8 a resident doctor in training? 9 A. So they're a resident doctor in training from the time 10 they take up their F1 post until the time they leave 11 training and they can leave training at various points 12 and we give various certificates of completion. So at 13 the end of foundation, the two-year training period, you 14 get a certificate of completion of foundation training. 15 That means that you are competent to work to a certain 16 level. Generally, it would be expected that a doctor 17 post-foundation training would still be working in 18 an environment that was supported. They wouldn't have 19 the evidence to be competent to practice independently 20 and operate at the level of, say, a specialist or 21 a consultant doctor. 22 Q. Right. So when one enters the training process, that 23 would be after the FY2 year; is that correct or ...? 24 A. So if you were going to enter core or specialty training 25 that would be after F2 but we consider the whole Page 85	1 registration as a GP or as a consultant on the specialty 2 register with the GMC and that gives an assurance that 3 that doctor has achieved certain competencies, has 4 knowledge and skills to enable them to practice 5 independently. 6 Q. So effectively if you look at it -- we're interested 7 obviously in neurosurgery, so if someone were on this 8 journey towards becoming a consultant neurosurgeon which 9 I think you said consultancy is the objective if one 10 stays in a certain path, if we could put it in that 11 context someone might get an MBChB from university, yes? 12 A. Yes. 13 Q. And then they would do the two years of foundation? 14 A. Yes. 15 Q. And then they would go into further training after that. 16 At what point would the surgical aspect kick in to that? 17 Does that kick in at the higher training point or is 18 that something -- if you were choosing to go down the 19 surgical route, where does that start? 20 A. So for many doctors that choice has already started to 21 formulate for them when they're at medical school and it 22 can influence their choice of training programme but it 23 would be post foundation they would enter into surgical 24 training. 25 Q. Right, so after the FY2 they would do certain Page 87
1 programme training from foundation forward. 2 Q. I see, so what comes after the FY2 year? 3 A. It depends on the pathway that the doctor chooses to 4 take. So in some programmes they go directly into 5 specialty training in ST1 and they do run-through 6 training until the completion of that training programme 7 and in other specialties they do what we call core 8 training which can be two or three years, and then at 9 the end-point of that core training, they can go on to 10 choose to leave the training programme and work at that 11 level in the health system. Again, it would be expected 12 that they would be working under the supervision of 13 a doctor who has a further qualifications and 14 a certificate that gets them on to the specialist 15 register. If they choose to continue into training they 16 would reapply and they then enter higher specialty 17 training and that can vary from between -- and a further 18 three, four, sometimes five years. 19 Q. Okay, so you said there were various routes out. 20 I think you mentioned the possibility of becoming 21 an employed doctor which is stepping out of the training 22 programme to do something somewhere else. What's the 23 ultimate objective if one stays within the training 24 programme? 25 A. So the ultimate objective is to achieve either a full Page 86	1 activities, rotations whatever, FY1, FY2. They might 2 still have the objective of becoming a surgeon, that 3 would be relevant to that, but they would focus on 4 surgery thereafter; is that correct? 5 A. Yes. 6 Q. And as regards the progression towards a consultant, we 7 heard some evidence yesterday from the chief executive 8 of the Royal College of Surgeons of Edinburgh and he 9 tried to fit in, in his evidence, what his organisation 10 might do to provide training and how that fits in with 11 the various other parts of the system. And in many ways 12 that's what we are trying to understand. One of the 13 things he talked about was becoming a member of the 14 college and becoming a fellow of the college and can you 15 help us with where that sits in the progression that 16 we've been talking about? 17 A. Sure. So the resident doctor in training would be 18 competitively appointed on to a surgical training 19 programme and they would then take up a clinical 20 placement that was designed for the level of experience 21 that they had, and to achieve the training milestones 22 that they need. 23 And we have four sites across Scotland that we 24 deliver neurosurgery training in as part of a national 25 programme. It is not sustainable to deliver Page 88

1 in individual hospitals and the resident doctor in 2 training wouldn't get all of the experience and exposure 3 they needed if they were to stay in one space. The 4 resident doctor in training would then go through the 5 progression of training, the various milestones on the 6 way, with opportunities for that progress to be reviewed 7 by a panel of educators and almost like gateways that 8 they would go through and at each of those gateways 9 there would be demonstrations of that doctor's abilities 10 and also evidence that the training environment was 11 supporting them to achieve those capabilities. 12 Within the surgical curriculum they would then be 13 supported in that early phase of training to undertake 14 the membership exam for the College of Surgeons and they 15 would get appropriate training and support, they would 16 have study leave and time to be able to undertake the 17 exam and then, with the exam and with progression on 18 an achievement of competencies, they would progress to 19 the final stages of training. 20 My understanding -- and I might need to check 21 this -- is that the fellowship exam of the Royal College 22 of Surgeons is one that's more of an exit exam. So it's 23 done very much towards the end of training so that that 24 doctor can demonstrate, both in written and a clinical 25 exam, that they have the competencies that the college Page 89	1 where learning stops. As doctors we expect every 2 professional to continue their professional development 3 and to evidence that through their appraisal. 4 Q. Yes, and if we were to revert again to the neurosurgical 5 hypothesis that we were discussing, you mentioned the 6 point at which someone would start to be looking for 7 a place in a surgical training spot. At what point 8 would someone start doing neurosurgery as a specialty if 9 that was their ambition, what point in the journey? 10 Would it be at that third year or would there be 11 something that comes in at a later stage? I think you 12 mentioned something about a specialist training? 13 A. So I would have to actually check. I'm uncertain, for 14 neurosurgery, whether that's a run-through training 15 programme or one that you enter post core training for 16 surgery. So we can check that. 17 Q. So a run-through would be one that you would start from 18 the third year and carry all the way through, is that 19 right? 20 A. So run-through would start post F2. 21 THE CHAIR: Sorry, what? 22 A. Post foundation 2, sorry. 23 MR DAWSON: So that's foundation year 2? 24 A. Yes. 25 Q. So in foundation year 3 you would start the surgical Page 91
1 expect that -- the college design the curriculum, we 2 support the delivery of that. But alongside that, 3 they're maintaining a portfolio throughout their 4 training where they're documenting the procedures that 5 they undertake, the skills and competencies that they 6 demonstrate. But also how they are experienced in the 7 workplace, so it's really important that we capture 8 feedback on how the doctor is as a colleague, as well as 9 how they are as a professional. 10 Q. Okay. Well, perhaps we'll get some of the details of 11 the training at a later stage. That's very helpful. 12 Just to pick up on a couple of aspects of that. 13 So the situation where someone has decided they want 14 to go down the surgical route, they would be looking for 15 a placement to be doing surgical work, they would then 16 sit the member of the Royal College exams that we heard 17 about. It seemed very much that that was sort of the 18 beginning of the journey, if you like, as far as the 19 Royal College was concerned but that there would then be 20 continued training thereafter leading towards the 21 fellowship being an exit exam and that would be the end 22 of the training, as you've called it. 23 Is that broadly correct? 24 A. That's broadly correct to achieve a certificate of 25 completion of training. Now that, of course, isn't Page 90	1 training. And in some disciplines that would run 2 through and you would be in that discipline throughout? 3 A. So it would be specialty training year 1. We don't have 4 a foundation training year 3, sorry, it is -- 5 Q. Yes, year three of the training, but surgical training 6 year 1? 7 A. But they may be graduates of more experience than that 8 because they may have stepped away from trained post F2. 9 So they're not necessarily all immediately after 10 foundation. 11 Q. Well, let's just try to keep the hypothesis as simple as 12 we can to try and understand the basic framework. But 13 whether neurosurgery is or is not, there are some 14 surgical programmes that would run through from the 15 third year of training, the first year of surgical 16 training, through to the completion. And there are 17 others that would have some general surgical training 18 and then would become specialists later; is that right? 19 A. So core surgical training and they would achieve more 20 general skills across different programmes so that they 21 were competent to enter into higher specialty training 22 for different surgical specialties. 23 Q. And the expression that we came to at the beginning, the 24 "registered doctor in training", what does the 25 "registered" bit of that mean? Page 92

1 A. Resident. 2 Q. Resident doctor in training, okay. So on the hypothesis 3 that we're discussing, the individual who is in training 4 is working in a hospital environment. I think you 5 mentioned something for neurosurgery about there being 6 four different sites where that can be taken and the 7 need to move to more than one, was that what you said? 8 A. Yes. 9 Q. So the four different sites are? 10 A. Ninewells, Aberdeen Royal Infirmary, the Queen Elizabeth 11 and Edinburgh. 12 Q. Yes, so there's Edinburgh, Glasgow, Dundee and Aberdeen, 13 basically. And is it therefore necessary within the 14 training, certainly as it exists now, to work in 15 a number of those; is that what you were saying? 16 A. Yes. 17 Q. So as to try and broaden the experience? 18 A. To broaden the experience and not all of the sites do 19 all of the procedures. 20 Q. Yes, so there's a general broaden of experience where 21 you get differences obviously from a different 22 environment but also some hospitals may not offer 23 certain surgeries, for example, that you would need to 24 become proficient in to reach the end of the training? 25 A. Yes. Page 93	1 an honorary fellowship that I was awarded about 2 seven years ago for the work I have done. So I wouldn't 3 practice under that. My clinical practice is under my 4 fellowship of the Royal College of Pathologists. 5 Q. Understood and I think there may be differences 6 depending on the field but is it the case that 7 fellowship exams are taken in specific clinical fields; 8 yours is medical microbiology? 9 A. For many colleges, yes. And there are also for some 10 colleges specialty-specific exit exams as well as the 11 fellowship. So it is a complicated landscape. 12 Q. I see. So the exit exams are not run by the college or 13 are they run by the college? 14 A. So they're run by the college and you have to pass those 15 exams if you're on a training programme to be able to 16 achieve your certificate of completion of training. 17 Q. I see. 18 A. There are other routes to getting on the specialist 19 register with the GMC and that involves presenting 20 a portfolio of evidence of your clinical practice, which 21 may or may not include having passed an exam. 22 Q. I see, and being on the specialist register with the 23 GMC, what does that mean in terms of the progress 24 that -- the progression that we've been talking about? 25 A. So when a doctor has completed their training and we Page 95
1 Q. With some hesitation, there's another aspect I'm going 2 to ask you about which is, again, using your 3 qualifications as an illustration. You're a fellow of 4 the Royal College of Pathologists and Royal College of 5 Physicians and it says "(medical microbiology)". 6 I wanted to ask you -- obviously we're looking at 7 surgical colleges largely, but I was interested to know 8 what the difference is in between being what appears to 9 be a general fellowship of the Royal College of 10 Pathologists and a more specialist one for the Royal 11 College of Physicians. Is that just because they 12 operated differently, or is there a difference? Because 13 one has medical microbiology and one does not. 14 A. So I wonder if that's a typing error in the statement 15 because I'm a fellow of the Royal College of 16 Pathologists (medical microbiology). So in my training 17 to be a medical microbiologist under the curriculum of 18 the College of Pathologists, I specialised in medical 19 microbiology and went on and followed that curriculum 20 and did those exams. So the fellowship -- 21 Q. I see, so the fellowship exam is in medical microbiology 22 for both? 23 A. Is in medical biology, yes. 24 Q. Yes, the reason I -- 25 A. So, my fellowship of the Royal College of Physicians is Page 94	1 have reviewed all of the evidence that they've 2 presented, and that we've gathered from the clinical 3 environment that they work, we can make 4 a recommendation. That is called "outcome 6" in the 5 annual review of competency progression and that means 6 that that doctor has completed all elements of their 7 training such that they are safe to practice as a day 8 one consultant. 9 We then make that recommendation to the GMC and the 10 college that they are awarded a certificate of training 11 in that specialty and the GMC then have them recorded on 12 their register under that specialty. So if you look up 13 a doctor on the GMC register it will say: this doctor 14 has or does not have an entry on the specialty register. 15 And that registration will describe the specialty that 16 they have evidenced completion of training in, it might 17 be general practice, it might be neurosurgery, it might 18 be medical microbiology. 19 Q. So just to get this right, the entry on the specialist 20 register is an indication that the individual has 21 completed their training in that discipline, if you 22 like? 23 A. Yes. 24 Q. Okay, thank you. Then as far as becoming a consultant 25 is concerned, does that then enable someone to apply to Page 96

1 become a consultant? 2 A. That enables somebody to apply to become a consultant. 3 Q. But doesn't make them automatically a consultant? 4 A. Not at all. 5 Q. Because alongside this, just to complicate it even 6 further, are the various grades of doctor that one might 7 see in a hospital which are really to do with their 8 employment progression, as I understand it; is that 9 right? 10 A. So if a doctor is in training their grades are 11 a reflection of the competencies and skills that they've 12 achieved and I think we've already described that the 13 "resident doctor in training" title covers many 14 different years and abilities and so we would also 15 describe what stage of training that that doctor was at. 16 But there are doctors who work outwith the training 17 programme who might be referred to as an associate 18 specialist, a locally employed doctor, a SAS doctor and 19 they've all got different levels of experience, some of 20 which are equivalent to, or approaching the equivalent 21 to consultant, and indicate that they are safe for 22 unsupervised practice. And others of them indicate that 23 that doctor needs to work under the supervision of 24 another clinician. 25 Q. So those people who you've mentioned step outwith the Page 97	1 A. Yes. So we convene panels called "annual review of 2 competency" panels, and they've got representation from 3 our deans, from the training programme directors and 4 from the environment where doctors are working and they 5 review the evidence that's been put forward. 6 THE CHAIR: Okay. Does it follow from that then that, at 7 least viewed from the prism of today, your organisation 8 is involved in quite a significant way in the process by 9 way a doctor achieves specialist registration? 10 A. Yes. 11 THE CHAIR: Yes, thank you. 12 MR DAWSON: Thank you, sir. The post that you hold has 13 changed slightly, I think, at least nominally, since the 14 statement. In the statement you described yourself as 15 the executive medical director of NHS Education for 16 Scotland, is that right? 17 A. Yes. 18 Q. And that's a post you held I think until April this 19 year? 20 A. Yes. 21 Q. And in April this year, as I understand it, there was 22 a re-organisation in the way NHS Scotland conducts its 23 business and NHS Education for Scotland was amalgamated 24 into a new body with other existing bodies and NHS 25 Education for Scotland is now part of that body; is that Page 99
1 training programme, there are other means by which they 2 can illustrate competencies such as to be able to be 3 licensed to carry out certain activities? 4 A. Licensed ... So "licence" is a tricky word because the 5 doctor, once they've got full registration, also has 6 a licence to practice but the licence to practice is 7 within the skills and competencies that you can 8 demonstrate that you have. 9 Q. Right. So you mentioned there, for example, being able 10 to work unsupervised. Would you have to be licensed to 11 do that? 12 A. You have to be licensed to practice clinically in the 13 UK. 14 Q. Okay. 15 THE CHAIR: Mr Dawson, could I ask a question? I do so with 16 some hesitation and it may be a product of my not noting 17 the evidence correctly or just my misunderstanding but 18 I'll try anyway. 19 When you were asked just now about the route to 20 specialist registration with the GMC you referred to all 21 of the evidence being reviewed and you referenced 22 something called "we": we review all the evidence and 23 can recommend something called "outcome 6". Should 24 I understand that to be the organisation whom you're 25 representing today? Page 98	1 correct? 2 A. Yes, it is. 3 Q. That body is Public Services Delivery Scotland, is that 4 right? 5 A. That's right. 6 Q. And as I understand it, you are now one of two medical 7 directors within that organisation? 8 A. That's correct. 9 Q. And your responsibilities, such as those that the Chair 10 asked you about, remain the same as they were before; is 11 that correct? 12 A. That's correct. 13 Q. And I think the position is that there is a period of 14 calibration going on as to exactly how the various 15 entities will work together going forward, is that 16 right? 17 A. Yes. 18 Q. But ultimately your role as you described it and the 19 services offered by NHS Education for Scotland continue 20 to be the same now as they were before that change? 21 A. That's correct. 22 Q. So we can take it that the evidence that's in your 23 statement and the various documents you provided still 24 represent how the various services relating to the 25 education of resident doctors in training and the Page 100

1 various other activities which the organisation pursues, 2 they remain the same now as they were in the statement? 3 A. That's correct. 4 Q. Thank you. You've also held a number of other roles 5 before in various different parts of the NHS and without 6 needing to look at any of them specifically, they 7 include, I think, being an associate and a deputy 8 medical officer in NHS Highland and as it happens -- and 9 you're an appropriate witness to ask this question to 10 early in our hearings. Could you tell us what a medical 11 director and a health board does, relatively succinctly 12 if that's possible? 13 A. I'll try. So a medical director and a health board's 14 primary responsibility is one of clinical governance of 15 patient safety and professional assurance of the doctors 16 that the health board employs. And they oversee the 17 frameworks through which safe care is delivered to the 18 population that that health board is responsible for. 19 Q. And are the doctors in the hospital answerable to the 20 medical director? 21 A. The doctors who are employed by the health board work 22 within the clinical governance framework of that health 23 board. Different doctors have different employment 24 contracts but wherever they are delivering the care, 25 they have a duty to work within the clinical governance Page 101	1 their medical director? 2 A. I'm the responsible officer. 3 Q. Yes, and the responsible officer effectively is someone 4 who is responsible for discharging those clinical 5 governance functions in law? 6 A. Yes. 7 Q. I think you mention in fact in your statement the 8 enactment or regulations by which that came in and we've 9 heard a little bit about that already. But as far as 10 other doctors who are working in a hospital are 11 concerned, the responsible officer to whom they are 12 accountable under these clinical governance frameworks 13 would be the medical director of that board or whatever 14 the employer is? 15 A. Yes. 16 Q. Thank you. You also held the post of an associate and 17 deputy medical director, I think. Are these posts which 18 may or may not exist within a health board in order to 19 assist the medical director in the discharge of his or 20 her functions? 21 A. Yes, it's exactly that. It's in an assistant to 22 delivering the function. So in my role as deputy 23 medical director in NHS Highland I had responsibility 24 for the acute clinical care delivery, so that care that 25 was delivered largely within the hospital setting. Page 103
1 frameworks in that environment. 2 I'm not trying to evade the question of: are they 3 responsible to the medical director? So the resident 4 doctors in training, for example, I would be expecting 5 them to work, whether they were in a local education 6 provider, whether that was their employer or if I was 7 their employer, within those frameworks. But for those 8 doctors I am the responsible officer, not the medical 9 director who is governing the clinical governance 10 systems in that health board. 11 But for doctors who are employed by the health board 12 and are not in training, they have a relationship via 13 the responsible officer status with their medical 14 director and the responsible officer status puts a duty 15 on that individual to ensure that the doctors are 16 working in a safe, supported environment that has strong 17 clinical governance frameworks and has systems in place 18 for learning to be continually improving clinical care 19 and patient safety. 20 Q. Right. So just to be clear, the medical director's 21 functions relate to the being in charge of the clinical 22 governance systems, yes? 23 A. Yes. 24 Q. And if a doctor is working, say, in a hospital in 25 a health board but is a doctor in training, you are Page 102	1 I had a counterpart who had that responsibility for 2 primary care, so largely the care that was delivered in 3 general practice and the community. But of course there 4 is an interface between both of those roles and a direct 5 report to the medical director. But that -- again, 6 discharging effective clinical governance systems and to 7 ensure patient safety is the key role. 8 Q. Thank you. And if I could look at it going in the 9 opposite direction, if you like. Does the responsible 10 officer have obligations to report upwards if you like 11 to other people within the health board or beyond? 12 A. So in terms of the responsible officer function, the 13 chief medical officer in Scotland is the high-level RO 14 for all responsible officers in Scotland. Of course, as 15 the medical director, in our role you have our 16 responsibility to your chief executive as the 17 accountable officer for the organisation with which 18 you're employed and so those two relationships are very 19 key and critical, particularly around the systems in 20 which we deliver safe patient care. 21 Q. And I think as it happens you also worked as a senior 22 medical officer in the Scottish Government health 23 workforce directorate; is that correct? 24 A. It is correct. 25 Q. So again, it might be helpful just to orientate Page 104

1 ourselves around that. That is effectively the 2 directorate through which, as I understand it, certain 3 healthcare services are delivered by the Scottish 4 Government, is that right? 5 A. So the health workforce department is the directorate 6 that has an oversight of -- and in the role I was doing 7 the numbers of doctors in training and their specialties 8 and where we would be having those doctors in training, 9 as it has other functions around ensuring that there are 10 adequate revalidation processes across Scotland. It 11 also looks at the funding of medical education and 12 training, both at undergraduate and postgraduate levels. 13 And I'm sure it has a multiplicity of other roles. 14 Q. Does it sit within the Health and Social Care 15 directorate or is it separate? 16 A. It sits within the Health and Social Care, yes. 17 Q. So it's a sub-directorate of the main directorate, 18 I understand. Where does the chief medical officer sit 19 within that? Did you work for the chief medical officer 20 or is the chief medical officer separate to that? 21 A. So I worked for the director of health workforce with 22 a professional line of sight to the chief medical 23 officer at the time. 24 Q. Right, is there a separate directorate for the chief 25 medical officer? Page 105	1 delivery of training, and the operation of delivery of 2 training. So if one were to hypothesise again, we're 3 back in our progression of the training programme, what 4 are the respective roles for those various different 5 things for, respectively, the GMC, now Public Services 6 Delivery Scotland, and, say, a health board if we're 7 talking about someone who is working within a hospital? 8 A. Okay. So talking now and not at the time of the 9 Inquiry, the General Medical Council now sets the 10 standards for education and training across the UK. It 11 also -- 12 Q. Would it be possible for me -- I don't mean to be rude, 13 but if I could just interrupt you because there are bits 14 you are going to say that are of particular interest. 15 So if we just say the GMC sets the standards. When you 16 say "standards", you mention I think in your statement 17 you make reference to a section 34H of the Medical Act 18 which sets out, without the need to go to it, very broad 19 responsibilities. It's the Act which basically sets up 20 the General Medical Council and this is one of its 21 subsidiary provisions relating to medical education. 22 And it sets out various high-level responsibilities of 23 the General Medical Council in that regard, such that 24 there would be various high-level steps that need to be 25 taken. Page 107
1 A. Yes, there is. 2 Q. That was my understanding, thank you. And you were 3 also, at one stage, the national lead for patient safety 4 for the Scottish Government. 5 A. Yes. 6 Q. What did that role entail? If you can, in a relatively 7 simple way, could you explain where that sits in the 8 architecture? 9 A. So I worked at that point for the quality directorate. 10 I don't think that exists any more within the Scottish 11 Government the Health and Social Care directorate. And 12 my role and remit in that space was really around the 13 interface of the Scottish patient safety programme, with 14 other key areas where we wanted to make improvements to 15 patient safety, such as reducing healthcare-associated 16 infection much but also looking at other areas such as 17 reducing venous thromboembolism such that we could be 18 continually improving care for patients. 19 Q. Thank you. Moving then back to the respond -- your role 20 and the responsibilities of what was NHS Education for 21 Scotland, now part of Public Services Delivery Scotland. 22 One of the other aspects that you mentioned -- I think 23 you mentioned, but correct me if I'm wrong -- that there 24 are various different organisations involved in the 25 various different parts of the setting standards, the Page 106	1 So as regards setting standards, in a practical 2 sense, what is it that the GMC does? Do they just say: 3 everybody needs to do everything that we say? Or do 4 they actually write down what the different standards 5 are? And how particularised are those standards? Are 6 they standards that are abstract concepts that apply to 7 everyone or are they done by field, or how does that 8 work in a broad sense? 9 A. So they're very specific standards around medical 10 education and training, and there is a document that we 11 provided to you which is standards for excellence. And 12 they are not in any way abstract and they make 13 reference, through five different theme areas, around 14 what organisations must do and occasionally there is the 15 use of the word "should", but in that document they're 16 very clear that educational standards are there in 17 service of patients and that there must be a very clear 18 and strong distinction made between the quality of 19 patient care and the quality of medical education 20 delivery. 21 And I think it would be really important to note for 22 this Inquiry that the medical training is done well, to 23 a high standard. It is part of our patient safety 24 architecture into the future because it is by those 25 standards that we've got clarity of what is expected, Page 108

27 (Pages 105 to 108)

1 we've got definitions of outcomes that we can measure 2 against and that enables us to (a) know if a doctor is 3 progressing through training, but also to look at 4 an environment where a doctor is learning and know if 5 that is in need of improvement or support or if it's 6 functioning well. 7 Q. And are those standards directed in particular at 8 anyone, at doctors in training, or the deliverers of the 9 training, or the architects of the training, or 10 everybody? 11 A. So we all have a role within those standards and so Good 12 Medical Practice is the standard document by which we, 13 as registered professionals, must align and that is 14 applicable for medical students as well as registered 15 doctors within the standards for excellence. The GMC 16 mark out really clear expectations both of statutory 17 education bodies -- NES, now PSD, is Scotland's 18 statutory education body -- and what we must do in terms 19 of our quality management and support of medical 20 education and training. But it's also really clear 21 about what local education providers should do/must do 22 in terms of providing a supportive environment both for 23 the resident doctors in training but also in terms of 24 those who are delivering education as clinical or 25 educational supervisors. Page 109	1 think they are not being met. 2 Q. So just to be clear though, is it the case that you 3 would then take the standards and then you create means 4 by which those standards can be delivered but you don't 5 actually do the delivery, is that right? 6 A. That's right. 7 Q. But also your function is to oversee that the delivery 8 is being done to a standard that you are policing 9 effectively, is that right? 10 A. Yes, I might not use the phrase "policing", but yes we 11 oversee and triangulate many different levels of data 12 that we receive, both from the local education 13 providers, around how they are delivering training. We 14 get feedback from the resident doctors in training, both 15 through surveys but also by having an open culture where 16 we invite doctors in training to let us know if they 17 have got experiences, good or bad. And we also monitor 18 the progression of our doctors in training both across 19 programmes, across regions and looking for signals all 20 the time for areas where we might be more curious as to 21 what is happening in a training environment such that we 22 can work in partnership with that environment to ensure 23 that they can deliver to the standards. And where there 24 are situations where that is challenging, we have 25 a mechanism where we can escalate that training Page 111
1 There's also expectations mapped out by the GMC for 2 universities and colleges in how they develop and design 3 the curriculum such that patient safety is at the heart 4 of all of those documents. 5 Q. Thank you. And I knew that we'd run into this at some 6 point, but I'm going to try to keep up with the 7 acronyms, but just to be clear, when you refer to "NES, 8 now PSD" what that means is NHS Education for Scotland, 9 now Public Services Delivery Scotland? 10 A. Yes. 11 Q. I think there may be more of those to come. 12 A. I'm so sorry. 13 Q. Not at all. So we got to the point of the standards 14 being set by the GMC. Then there are other bodies, I 15 think, that are involved in the delivery of the training 16 but also in the creation of the training and the 17 oversight of the training. Can you explain which bodies 18 are involved in those aspects? 19 A. So NHS Education for Scotland, now Public Services 20 Delivery Scotland is the statutory education body for 21 Scotland. As I've said already, each devolved nation 22 has a statutory education body and their function is to 23 ensure that training of doctors meets the GMC standards 24 and that there are systems in place to ensure that those 25 standards are being met and to be able to detect if we Page 110	1 environment to the GMC under a system called "enhanced 2 monitoring", and that enables us to provide more support 3 and to look for more data and ensure improvement is 4 happening in a much more active way than just that 5 system scanning that we go on. 6 Q. So you're overseeing both -- I think you used the 7 expression earlier "local education provider". I think 8 that might be an acronym as well, but we avoid it but 9 I've seen the acronym in the statement. That would be, 10 for example, a hospital delivering training to a doctor 11 in training, yes? 12 A. Yes. 13 Q. And you are overseeing both those bodies but you're also 14 overseeing the resident doctors in training as well? 15 A. So we are overseeing the resident doctors in training in 16 how they are progressing and the local education 17 provider -- I don't think it's an acronym, I think it's 18 a description of where training takes place, a general 19 practice is a local education provider. A hospital is, 20 as is a health board. But also we look down into the 21 granular detail of the different clinical environments. 22 Q. When you say "clinical environments", what do you mean 23 by that? 24 A. So that can mean a ward or a clinic area. 25 Q. Right, so in the sense that you've got a granular Page 112

1 operation and trying to make sure everything that is 2 being delivered is supporting the training in the best 3 way it can be? 4 A. With the focus of patient safety at the end, yes. 5 Q. Yes. So what we have said about the local organisation 6 or hospital would be responsible for the delivery, but 7 Public Services Delivery Scotland is not responsible for 8 the delivery, is that correct? Other than overseeing 9 it? 10 A. So we're not responsible for the delivery of the 11 clinical education in the clinical environment. So that 12 is very much investment the responsibility of that 13 clinical area and for that to be done within the bounds, 14 as we've described already, of their standards and 15 particularly around clinical governance. The reason 16 I'm hesitating slightly is that we do deliver in terms 17 of specialist training days for resident doctors in 18 training. We also have specialist environments such as 19 the NHS Scotland Academy where the doctors can go for 20 immersive training and we also develop education 21 resources that the doctors in training can access. But 22 in terms of the hands-on, clinical skills then that 23 would not be our -- what we do. 24 Q. Thank you. And you've helpfully told us I think NHS 25 Education for Scotland came into being in 2002, is that Page 113	1 there being perceived to be a value in bringing together 2 and centralising the education of these professional 3 bodies in one place, is that right? 4 A. That is my understanding. 5 Q. Do I take from that -- and I understand that's your 6 position looking back and trying to be helpful to us -- 7 that there wasn't any sense of dissatisfaction with the 8 way that things worked previously, other than there 9 would be a benefit in centralisation? 10 A. I can't answer that question, I'm really sorry. 11 Q. And as far as -- one of the aspects of the statement 12 that's of interest to us is what it is that your 13 organisation, which I'm taking -- let's call it NHS 14 Education for Scotland -- could tell us about that 15 period? Because obviously the period we're interested 16 in although 2002 onwards is of interest to us, we're 17 interested in the period before that back to 1995 when 18 the Scottish Council for Postgraduate Medical and Dental 19 Education would have been the body performing this sort 20 of function. You said that you don't have access to any 21 documents from that body; is that right? 22 A. That's right. 23 Q. And have told us that they have been destroyed in 24 accordance with a document retention process. Is that 25 right? Page 115
1 right? 2 A. Yes. 3 Q. And that came into being as a result of, as we've 4 encountered more recently I think, a number of bodies 5 being amalgamated together in a single body; is that 6 correct? 7 A. Mm-hmm. 8 Q. And the bodies that existed previously were bodies which 9 were responsible for overseeing education in various 10 different professional fields, is that right? 11 A. Yes. 12 Q. I think they covered -- there was the postgraduate 13 medical and dental education -- Scottish Council for 14 Postgraduate Medical and Dental Education, which was the 15 one that was particularly involved with doctors -- 16 A. Yes. 17 Q. -- and dentists. Whereas there were other bodies that 18 were responsible for, I think, nursing, midwifery and 19 pharmacy. There being a pharmacy one, a midwifery and 20 the three came together into one body, is that right? 21 A. Yes, that's right. 22 Q. And I think you've tried -- it's appreciated -- to help 23 us with understanding why that happened at that time. 24 My impression from the statement is that it was 25 an administrative decision and a decision based around Page 114	1 A. That is my understanding. 2 Q. Yes. Are you, quite reasonably, assuming that that is 3 the case because they should have been in accordance 4 with those procedures or do you know that there are no 5 documents? 6 A. It's my understanding that that is what would have 7 happened in accordance with the retention policy. I do 8 not know that for a fact. 9 Q. It's just the reason I ask is because it may well be 10 that your organisation works differently from others but 11 it has been our experience so far that there have been 12 assumptions sometimes made that because of the existing 13 government guidelines or retention schedules that there 14 won't be documents. But in fact, on further inspection, 15 there are in fact documents that have been retained 16 beyond the retention schedule or scheme deadlines. So 17 what I'd be interested in knowing -- and I know it 18 wouldn't be your job, someone within your 19 organisation -- as to whether one can entertain the 20 possibility that they might exist despite those and 21 whether searches could be done to try to make sure that 22 there aren't? 23 A. Absolutely, if that's helpful to the Inquiry. 24 Q. Yes, it certainly is, simply because you also have 25 offered us no indication -- not meant as a criticism, Page 116

1 you just don't know, I don't think -- as to where any 2 documents pertaining to that body might be if they do 3 exist. One place that we have tried to look for 4 documents is in the national archives and we continue to 5 do that but it would not be uncommon in our experience 6 for organisations today to assume that documents don't 7 exist but in fact for documents to be turned up 8 somewhere. So if that would be something that your 9 organisation would be prepared to do, it would be 10 extremely helpful because obviously we're interested in 11 that earlier period as well and we accept there are 12 limitations on what certainly you can tell us about it. 13 I think you also helpfully told us there are other 14 people who may still be available, including one 15 particular gentleman who may have worked for the 16 previous body who held a senior position in NHS 17 Education for Scotland about the time of the transition, 18 is that right? Is that your understanding? 19 A. Yes, that's my understanding. 20 Q. I think also, as I understand it, there are other 21 individuals who have held senior positions who have gone 22 on to hold other positions in other places. One, for 23 example, was Caroline Lamb. As I understand it, she 24 held a senior position in your organisation. We are, in 25 fact, hearing from her in a different capacity later on Page 117	1 A. And the GMC then approves them. There's a process 2 whereby they have a curriculum oversight group and the 3 GMC is always interested in how are these going to 4 ensure safe standards of care and patient safety but 5 also are they deliverable and fit for purpose for our 6 health system. 7 Q. There's another concept in what I've seen "competency 8 frameworks". What are they? 9 A. So they are part of a curriculum document. So they 10 would be describing what it is we would expect a doctor 11 to be able to do and how they would demonstrate those 12 either technical or clinical skills. 13 Q. Okay, and as far as -- could you give an example of the 14 sort of area, the breadth of area, if you like, or 15 a particular area that a curriculum would exist for? 16 A. So for each of the, I think it's 67 specialties that we 17 have across the UK, they would all have their own 18 curriculum document. 19 Q. So would neurosurgery be one, for example? 20 A. Yes. 21 Q. And then a competency framework, how would that work 22 within the neurosurgical curriculum? 23 A. So it would almost bring to life certain aspects that 24 an educational environment would be looking at both in 25 terms of what it could deliver and how it would assess Page 119
1 in this Inquiry and so there may also be people who can 2 help, who perhaps were nearer those events. Is that 3 correct; is my understanding correct? 4 A. Yes, that would be correct. 5 Q. Thank you very much indeed. As far as the way in which 6 the educational provision is delivered, there are some 7 phrases which are no doubt very familiar to you which 8 float about in the statement which I struggled with 9 slightly. There is a mention, for example, of there 10 being a curriculum or curricula that play an important 11 role. Could you tell us a bit about that? 12 A. Yes, so each specialty has a curriculum that is 13 described by the relevant Royal College and that 14 document describes the skills, competencies and 15 knowledge that a doctor needs to acquire to become 16 a specialist in that specialty. So our role is around 17 the delivery of that -- 18 Q. So -- 19 A. -- curriculum. 20 Q. -- just to be clear, the curriculum comes from the GMC, 21 is that right? 22 A. No so the curriculum comes from the Royal College and 23 then the Royal College presents those documents to the 24 GMC. 25 Q. Yes. Page 118	1 a resident doctor in training to have achieved those 2 skills, acknowledges, behaviours. And so it very much 3 distils out from the curriculum what it is we might 4 expect to see. 5 Q. And are -- who's responsible for the creation of the 6 competency frameworks? 7 A. That would be the colleges. 8 Q. Sorry, say that again? 9 A. The colleges. 10 Q. The colleges, right. So you would then be using these 11 curricula and competency frameworks and your job is try 12 and work out a way that can be delivered, not in the 13 immediate sense, but to provide mechanisms by which the 14 education can flow and be used in a hospital or whatever 15 at the end of the day, is that right? 16 A. That's right. 17 THE CHAIR: Just -- I think you possibly clarified that in 18 your question, Mr Dawson, because I was a little 19 confused by your reference to you delivering the 20 curriculum and the position of the local education 21 provider who delivers it as well but in a more immediate 22 sense. But you're the kind of bridge in between, you 23 facilitate the process by which the curriculum filters 24 down to the provider of education? 25 A. That's correct. Page 120

1 MR DAWSON: As far as the structures are concerned, this is 2 definitely an area we've struggled with as to the 3 various different positions and I'm not sure about the 4 extent to which it's affected by you helpfully having 5 provided evidence to us about the period before NHS 6 Education for Scotland and after. But there are 7 various, it would appear, important roles in the 8 delivery of this overarching mechanism and in that, in 9 some place feature deans and a deanery. I understand 10 that something called the "all Scotland Deanery" may 11 have come about as part of NHS Education for Scotland's 12 activities in around 2014 which suggests there was some 13 sort of change. Beyond that, it would be very helpful 14 if you could try to help us understand how the deaneries 15 and deans worked and work after that date, in particular 16 it would appear there may be deans sort of on both sides 17 of the fence in the recipient and the deliverers of 18 training and in those who provide the training. So if 19 you could try to give us a sort of tutorial, if you 20 like, on how that works that would be extremely helpful. 21 A. I will do my best. 22 Q. Thank you. 23 A. So if we look back to 2009/10 in Scotland there were 24 four deaneries, the east, the north, the south east and 25 the west. And those deaneries operated within the NHS Page 121	1 be training. Do they understand what the curriculum is 2 for that specialty, have they understood the skills and 3 competencies those doctors have and are they properly 4 supported? So that would have been the structure as it 5 was in -- 6 Q. So just to be clear, all of those different roles going 7 down from the dean, associate dean and below that for 8 a specific course, they were all within the NHS 9 Education for Scotland structure and then once you got 10 down to the most local part you were engaging with 11 I think you called it an educational supervisor, was 12 that right? 13 A. Educational supervisor or clinical supervisor. 14 THE CHAIR: Sorry, was it one or the other or both? 15 A. They're both. They're different roles. 16 MR DAWSON: And again, I don't know whether there's 17 difference in time. You were telling us about the 18 system that existed around about 2009/10. The change in 19 2014, I think, was that they stopped having the four 20 centres and became an all-Scotland operation, 21 a centralisation of the functions. 22 A. Yes. 23 Q. But as far as more historically is concerned can you 24 help us as to whether that deanery-type structure 25 existed back to 1995 from 2009/10, or was that something Page 123
1 Education for Scotland structures and the deans oversaw, 2 within the geographical area that they were based, all 3 of the training and education across all of the 4 programmes in that area. 5 Q. So just to clarify, Dundee would be in the East, 6 Tayside, yes? 7 A. Yes. 8 Q. Thank you. 9 A. And that would have been one of the smaller deaneries in 10 Scotland. 11 Q. Okay, so that wouldn't cover Edinburgh, for example, 12 then? 13 A. No, that would be south east. 14 Q. Thank you. Please carry on. 15 A. And within the deanery structure the deans, at that 16 point, would have had associate postgraduate deans who 17 had specific programmes that they were responsible for 18 in that region and there would be a role called 19 a "training programme director" which is getting much 20 closer to where the individual resident doctors in 21 training are and they look after a specific rather 22 programme and they support the trainee primarily but 23 also ensure that the educational and clinical supervisor 24 who are employed by the health board, the local 25 education provider, know what it is they are supposed to Page 122	1 that was -- how far back can you help us? 2 A. I don't know. I'm really sorry, but we can find out. 3 Q. Okay, well, I have certainly seen mention of there being 4 postgraduate dean and things at an earlier stage than 5 that, but we can certainly look into that. So as far as 6 the systems are concerned, was there always, at the 7 ground level if you like, the delivery person, that is 8 a supervisor of one kind or other, is that right? 9 A. Yes. 10 Q. So the supervisor might be someone like a consultant 11 surgeon who is providing training in a theatre to 12 a surgeon in training, a resident doctor in training who 13 is doing the surgical course; is that correct? 14 A. That's correct. 15 Q. And you differentiated between two types of supervisor 16 which I think there are -- I think there's a clinical 17 supervisor and an educational supervisor, is that right? 18 A. That's correct. 19 Q. And the clinical supervisor would be the one responsible 20 for the sort of thing I just described I think which 21 would be providing technical education and skills to 22 someone, say, in surgery to carry out a particular 23 procedure, something like that, is that right? 24 A. That's correct. 25 Q. That would be why, perhaps, people are now required to Page 124

1 work in different hospitals because they wouldn't have 2 exposure to the different procedures, as every hospital 3 might not offer the ones that you need, as we said 4 earlier, is that right? 5 A. Yes. 6 Q. What about educational supervisor, what is that? 7 A. So, the educational supervisor sits in a different space 8 in the educational journey and is looking not just at 9 how the doctor is acquiring those specific technical 10 skills but how are they progressing through their 11 educational journey. And it's quite important to have 12 a different person in that relationship because it gives 13 the resident doctor in training an opportunity, if 14 they've got worries or concerns, to have somebody else 15 that they can talk to, reflect with and I think that 16 that is quite important. 17 Q. Is it essential that someone have different people in 18 those two roles? 19 A. So it's an interesting question because we do have some 20 programmes where they are delivered by the same person 21 but I think we must always be really aware in that 22 relationship that the resident doctor in training may 23 have an area where they are not necessarily feeling that 24 they could be supported and that's why we have our 25 training programme directors and they have a very strong Page 125	1 Q. So, I remember this. It is something like you pay 2 a part of their salary or something like that for them 3 to perform that function for you but they are otherwise 4 working as a consultant or something like that in the 5 hospital, let's say, is that right? 6 A. That's right, yes. 7 MR DAWSON: Okay, that's excellent. Sir, that would be 8 a convenient moment for a break. 9 THE CHAIR: Yes. We'll stop now for about 15 minutes. For 10 the sake of good order and discipline we ask witnesses 11 not to discuss their evidence while the break is going 12 on and we'll come back in about 15 minutes, if that's 13 convenient. Thank you. 14 (3.15 pm) 15 (A short break) 16 (3.30 pm) 17 THE CHAIR: Thank you, Professor. We are ready to resume, 18 I think, Mr Dawson. 19 MR DAWSON: Thank you very much, sir. We were talking about 20 clinical and educational supervisors and I was 21 interested to try to ask you some more broad questions 22 about the functions and remit of NHS Education for 23 Scotland specifically because I'm interested in the 24 period from 2002 but if there's any reflection you can 25 give on the earlier period that be helpful. Page 127
1 relationship with the resident doctors in training and 2 they would be seen, again, as somebody else that the 3 resident doctor in training could look to both for 4 learning but also if there were something going on. But 5 largely we do try and have the separate roles. And 6 a consultant could be a clinical supervisor for one 7 doctor and an educational supervisor for another doctor, 8 so they could hold roles but not be for the same person. 9 Q. But one can imagine, as I think you said, there could be 10 a value in the separation in the sense that it might be 11 useful to have two different people and two different 12 perspectives on things in two different areas; is that 13 the thinking behind that? 14 A. That is the thinking. 15 Q. And the role that you mentioned as being a potential 16 third person you could go to, or second person if it was 17 the same person, what was that role? 18 A. The training programme director. 19 Q. Right, and is that someone within the -- I was going to 20 use the acronym there, the NHS Education for Scotland 21 structure, or is that someone within say the hospital 22 structure? 23 A. So that is a doctor who we employ through NHS Education 24 for Scotland on, generally, a service level agreement 25 basis with whoever their lead employer is. Page 126	1 You've explained so far aspects of the role of NHS 2 Education for Scotland but in the specific context of 3 the clinical and education supervisors, did NHS 4 Education for Scotland have a role in overseeing, 5 monitoring, regulating them to an extent in that 6 function? 7 A. So NHS Education for Scotland's role in relation to 8 clinical and educational supervision was to provide 9 training for those individuals who were undertaking 10 those roles. And that training has developed over time. 11 I think you'll see from the evidence that the 12 General Medical Council became very interested in the 13 role of clinical and educational supervisor such that 14 they wanted to put much stricter boundaries around that 15 role and expectations and so with that came a need to 16 revise the training. So the training that NHS Education 17 for Scotland delivered through the Scots courses was 18 seen across the UK as very high standard training but it 19 needed to be developed and adapted to support clinical 20 and educational supervisors to the new standards. 21 Q. So just to tie it into the other evidence. NHS 22 Education for Scotland had an oversight function of the 23 local deliverers of training and of the resident doctors 24 in training and it provided training to clinical and 25 educational supervisors to undertake their function but Page 128

1 it did not oversee them in the same way, is that right? 2 A. That's correct, that responsibility lies with the local 3 education provider and the health board. 4 Q. Yes, I was going to ask you because frequently 5 throughout the statement, when asked questions around 6 this area, and in particular the possibility that NHS 7 Education for Scotland could have become aware of or 8 done something about complaints related to Mr Eljamel in 9 the broader sense, concerns, you say I think that that 10 would be a matter for the employer, it would be a matter 11 of the employment relationship rather than something 12 that was in any way really in NHS Education for 13 Scotland's responsibility? 14 A. Yes, that's correct. 15 Q. You do, however, say -- and I think you mentioned it 16 earlier in our conversation about the three potential 17 people someone could go to -- that it would be possible 18 for concerns of that nature to come to the attention of 19 people working for NHS Education for Scotland carrying 20 out their various functions. It might, for example, 21 I think be possible for a resident doctor in training to 22 go to their connection within NHS Education for Scotland 23 to say: the training I'm getting is not what I was 24 expecting or I'm struggling with aspects of it. I think 25 you told us about that a moment ago. So that would have Page 129	1 associate postgraduate deans having discussions with the 2 clinical director or associate medical director. What 3 we would then do is ascertain whether we would need to 4 intervene at all. Sometimes the information we get from 5 resident doctors in training necessitates that we go and 6 visit the educational environment and meet with other 7 colleagues. 8 At the whole system it's really important that the 9 doctor who has raised the concern feels safe in having 10 done so and feels that they are doing the right thing. 11 There's been a culture over years within the medical 12 profession that perhaps speaking out isn't the right 13 thing to do. So we are trying to ensure, through all of 14 our systems and processes, that speaking out is 15 absolutely the right thing to do, even if, on further 16 investigation, that there's nothing to find because 17 a resident doctor speaking out takes a lot of energy, it 18 takes a lot of bravery and it's really important that 19 that's recognised. 20 We have situations live at the moment where concerns 21 have been brought to us by resident doctors in training 22 and they have resulted in interventions from us in 23 partnership with the health board to improve the 24 learning environment and I would say improve outcomes 25 for patients in doing that. Page 131
1 been a mechanism by which that could have come to the 2 attention much someone working for NHS Education for 3 Scotland, is that feasible? 4 A. So that is feasible but we've got no evidence that that 5 happened. 6 Q. In Mr Eljamel's case? 7 A. Yes. 8 Q. I'm just talking here about the systems. But in such 9 cases, what would it be likely in that hypothesis that 10 NHS Education for Scotland would have done, given its 11 limited regulatory or oversight role over a supervisor? 12 Would it have reported somewhere else is really what 13 I'm getting to? 14 A. So I can talk to what I would do now but I can't talk to 15 what would have happened then. So we do become aware of 16 situations in health boards and clinical areas and 17 sometimes in general practices because of the 18 information that comes to us from resident doctors in 19 training via their training programme director or 20 associate postgraduate dean, so the very first thing 21 that we do in that situation is ensure that the resident 22 doctor is safe and that they are not coming to harm. 23 And then we set about triangulating the information 24 and that often includes having conversations with my 25 equivalent in a health board or with one of my deans or Page 130	1 Q. Okay, thank you. And if we stick to what you know about 2 which is how things would work today, would that 3 reporting route, if you like, by a resident doctor in 4 training cover situations in which the resident doctor 5 was being bullied by a superior? 6 A. Yes, absolutely. 7 Q. Would it cover situations in which the resident doctor 8 in training was being intimidated by a superior? 9 A. Yes. 10 Q. Would it cover situations in which the resident doctor 11 in training felt that there was inadequate supervision 12 of their medical work by their supervisor? 13 A. Yes, it would. 14 Q. Would it include situations in which the resident doctor 15 in training felt that the workload being imposed upon 16 them was excessive? 17 A. Yes, it would. 18 Q. Would it include circumstances in which there were 19 concerns about the supervisor, or a consultant working 20 higher up, not being sufficiently present in the 21 interests of patients for surgeries or other medical 22 treatment? 23 A. Yes, we would want to know about all of those things. 24 Q. Okay. And would it include circumstances in which there 25 were concerns about the way in which other systems in Page 132

1 the hospital were operating? So, for example, one thing 2 you touched on in the statement which sounds like a sort 3 of PhD thesis itself is the relationship between 4 clinical governance and educational governance which 5 sounds like a fascinating topic, but, for example, it 6 might be the case that a resident doctor in training 7 would come to you or one of your colleagues because 8 there had been a failure in their ability to escalate it 9 within the hospital systems. Would that be something 10 that might happen? 11 A. Yes, that is something that does happen. 12 Q. Yes, as an outlet, if you like, because the systems that 13 are meant to exist may not operate sufficiently? 14 A. Yes. 15 Q. You said a moment ago, I think, that there had been 16 a historically -- and you're a long-standing medical 17 professional yourself -- a culture of not speaking up in 18 the medical profession. Is that something which is 19 borne out of your own professional experience or is that 20 now, within the medical profession, widely accepted? 21 A. So I think if we look back at why the changes have 22 happened across medical education and training from 23 a time where colleagues were trained in more of 24 an apprenticeship model in a local system and there was 25 a reliance perhaps on patronage and local relationships, Page 133	1 we can support making things better and we very much see 2 our role in what was NHS Education for Scotland, now 3 PSDS, as supporting clinical environments to improve and 4 supporting structures and frameworks such that it is 5 unacceptable for bullying and undermining, sexual 6 misconduct, people working outwith their competency. So 7 we see that as a very important role of educational 8 governance. 9 Q. Okay, but two aspects of the evidence you've given that 10 I just wanted to try to -- if you could help us orient 11 in time a bit as to when things changed. One, you 12 talked about the GMC taking a greater interest in 13 clinical educational supervisors. Can you orientate us 14 roughly when that was happening? I know you've provided 15 some information, but just for the information of people 16 listening. 17 A. So there was a significant piece of work undertaken by 18 the GMC to look at the role of the clinical and 19 educational supervisor and the importance of that role 20 and how those colleagues were selected, trained and 21 supported such that they built the "recognition of 22 trainers" framework and that was launched -- and I would 23 have to back to my notes and I haven't taken my folder 24 with me, but I think it was launched in 2014 and 25 implemented in 2015. And at that point all of the Page 135
1 that culture of potentially a lack of externality might 2 have created an environment where it might not have felt 3 safe to speak up if you saw or experienced some of the 4 elements that you described just a moment ago. 5 I think that has been recognised by us as 6 a profession, by our regulator and it's why the 7 standards have not only come into place but been 8 strengthened and then been sat with the GMC such that 9 the importance of providing a safe, structured, 10 standard-led environment for medical education and 11 training and that absolute link to patient safety. 12 And I think that is, in itself, an acknowledgement 13 that the way we were as a profession isn't the way we 14 are now. I still think that culture is a challenging 15 thing to change and so we have to be really, really 16 intentional to ensure that our resident doctors in 17 training know they are supported. I myself went to 18 an event with resident doctors in training only last 19 week to be there in person, to let those doctors know 20 that if they are experiencing anything in terms of 21 bullying, undermining, seeing things that they don't 22 think are quite right, that they have not only 23 an expectation but a duty to speak out and that we want 24 to hear. Because it's only through hearing and knowing 25 of those resident doctors in training's experience that Page 134	1 health boards and the universities had to identify 2 colleagues in key educational roles. They had to 3 demonstrate that those colleagues had been selected, 4 that they had the time to do the role and that they were 5 trained to do the role and that they had a full 6 understanding of what that role was. 7 And then I think, really importantly, that they were 8 appraised in that role annually. So they had to bring 9 evidence of being able to do the role and what the 10 feedback of them in that role is and that's part of our 11 revalidation and appraisal process. 12 Q. Yes and was that the responsibility of NHS Education for 13 Scotland or did that sit somewhere else? 14 A. So our responsibility in that space was to provide the 15 training but also to hold the register of the doctors in 16 Scotland who have those recognition of trainer roles. 17 Q. But the revalidation and appraisal process is someone 18 else's responsibility? 19 A. That's the responsibility of the employing health board. 20 Q. Thank you. And the other aspect that you've been 21 telling us about that I wonder if we can orientate in 22 time, you mentioned there being a shift between what we 23 have now which is an educational system which seeks to 24 deliver care in a more patient-focused way and you 25 contrasted that with an older system which I think you Page 136

1 said was more locally delivered, involved 2 apprenticeships and sometimes patronage. You do mention 3 that in your statement as there being an older system 4 and a system which attempts to be more structured and 5 inclusive and patient-orientated. Can you help us 6 with -- there are various changes happening in your 7 statement, various changes of bodies, various 8 regulations coming in. Is it possible to pinpoint when 9 that change started to happen or over what period it 10 happened and what particular developments were 11 associated with it? 12 A. So in terms of -- I think one of the key areas was when 13 the colleges were working together to ensure that they 14 were describing standards. The Postgraduate Medical and 15 Education Training Board came into being I think in 16 about 2007, and that was the first time there was 17 a national oversight of the quality of medical education 18 and training and that assessment that a doctor had 19 achieved completion of training. And I think they 20 awarded a certificate of specialty training completion. 21 The acronyms get me too. 22 That entity was present, I think until 2010, when 23 the Medical Act was revised to sit the function of 24 educational standards with the GMC and it has been 25 enduringly with the GMC since then. And as I described Page 137	1 actually, it's paragraph 10.7, please. You tell us 2 there: 3 "In 2013, a public inquiry (Francis) about a serious 4 failure of a healthcare system in England made a number 5 of recommendations. One of these was to improve 6 intelligence sharing within and between national 7 agencies. This is to allow earlier identification of, 8 and response to, the signs of a potentially serious 9 system failure. In response to this, the Sharing 10 Intelligence for Health and Care Group was established 11 in 2014 which has resulted in much better sharing and 12 consideration of key pieces of data and information by 13 the Scotland-wide agencies involved. These agencies are 14 now better prepared to take additional action, when this 15 is required. The Sharing Intelligence for Health and 16 Care Group inaugural report -- May 2016 has been 17 provided ..." 18 And under paragraph 10.8, you say that NHS Education 19 for Scotland and Healthcare Improvement Scotland: 20 "... co-lead the Sharing Intelligence for Health and 21 Care Network. This is a network of organisations 22 working in health and social care to connect, share 23 insights, and develop best practices in the use of data 24 and intelligence. Its primary aim is to enhance the 25 quality, safety, and effectiveness of health and care Page 139
1 earlier on this afternoon, I think there has been a very 2 strong mechanism for ensuring that there's a connection 3 between the educational environment that a doctor trains 4 in, the clinical environment that a doctor practices in 5 and that role of the GMC both in registering doctors but 6 also in overseeing the fitness to practice. So that 7 bringing together I think has strengthened and 8 formalised the system. 9 Q. So that change in approach from 2007 to the training 10 environment, you're saying I think is indicative or 11 a part of a wider change in attitude to the way that 12 medicine should be delivered, is that correct? 13 A. Yeah, I think that is what I'm saying. 14 Q. Thank you. In your statement -- we can go to it if you 15 need to -- you were telling us a moment ago about 16 a circumstance in which, at least today, issues being 17 experienced by a resident doctor in training could be 18 escalated or brought up within your system. One of the 19 things we're interested in asking about and you've 20 provided some useful information about was the extent to 21 which information could be shared amongst agencies or 22 between agencies which were indicative of concerns about 23 certain practices or concerns about other things that 24 were going on in a hospital, let's say. 25 And you tell us about -- if we can just go to it Page 138	1 services by promoting informed decision-making through 2 better access to and understanding of data. 3 And you mention the report. 4 I think that may be a reference to the Mid Staffs 5 Inquiry which was delivered by Sir Robert Francis. This 6 is an area of interest to us about the extent to which 7 data which is held within individual silos, when put 8 together might give a different or fuller picture of 9 problems occurring. And it was interesting to know NHS 10 Education for Scotland and I presume the new body in 11 Healthcare Improvement Scotland co-lead the health and 12 care network. 13 What are the sort of prevalent attitudes now around 14 sharing information or to try to achieve various aims 15 that have been set out there? And in that regard, what 16 role does the network play in trying to promote that 17 objective? 18 A. Thank you. So the network that exists in Scotland is 19 formed of the regulators who are based in Scotland, so 20 that would be the GMC, the NMC, we've representatives 21 from the General Dental Council, Pharmacy Council, 22 Ophthalmic Council, as well as the Care Inspectorate, 23 Mental Welfare Commission, NES, HIS, the Audit Scotland 24 and the SPSO. And what they do together is share 25 information that would be of interest to the other Page 140

1 parties, exactly as you say, to try and form a bigger 2 picture of what is going on across the health and care 3 network. 4 And then the network discusses data or information 5 that is brought to that network and considers whether, 6 as a network, anything needs to be done differently or 7 if responsibility can rest with the relevant party who 8 brought forward the information. 9 What we have seen in that network is opportunities 10 to see potential areas earlier, perhaps, and to escalate 11 them through the chief executives of Healthcare 12 Improvement Scotland and what was NHS Education for 13 Scotland for additional support. The network is, again, 14 continually reviewing what it does and its place in the 15 Scottish system to ensure that it is not overstating its 16 aims but also acting to the Terms of Reference that it 17 has. 18 Q. Okay, thank you for that. I was interested to ask you 19 a few questions, without getting into any level of 20 detail at this time, about the sorts of attitudes 21 towards training that might have developed under the 22 more sophisticated system of delivering training to 23 resident doctors. 24 It is a phrase that we've seen as regards the way 25 that surgical training might work, that we've come Page 141	1 that's useful for us -- is the training that you 2 facilitate the delivery of a full range of medical 3 training for a resident doctor? So we heard yesterday 4 in a slightly different context about training being 5 delivered by the Royal College in a technical context -- 6 this is surgery, of course -- and a non-technical 7 context. And we also heard about the importance placed 8 by the Royal College of Surgeons of Edinburgh on matters 9 that would not perhaps traditionally be associated with 10 surgery, how to do the surgeries and that sort of thing, 11 but other types of qualities that they would wish to 12 promote and indeed, a considerable amount of work being 13 done in that area by the Royal College. And there was 14 mention of the importance of training, including the 15 importance of candour, and probity, and that sort of 16 thing, communication. We talked a little bit with 17 a witness this morning about the importance of being 18 trauma-informed with patients and that sort of thing. 19 Without getting into the specifics, does your remit 20 cover delivery of training across all of those areas? 21 A. Yes, it does. 22 Q. And is it correct to say, as we understood, that there 23 has been an increased emphasis in recent years on those 24 non-technical skills? 25 A. I would say that there has been a significant increase Page 143
1 across, which is perhaps -- you may or may not recognise 2 it -- it may be redolent of an older system of medical 3 training, if you like, if one can even call it that, 4 there is what one call a "see one, do one, teach one" 5 model which is redolent of a sort of system of quite 6 rudimentary medical education. Is that something that 7 you would recognise as being part of the sort of older 8 system where busy surgeons would expect their resident 9 doctors in training at that time to pick things up very 10 quickly and there was perhaps inadequate attention to 11 their needs and whether they had sufficiently understood 12 what they were now being expected to do? 13 A. So I can't talk to that but what I could say is that 14 isn't how we would educate and train doctors now. 15 Q. Yes. And I suppose, to some extent, you have recognised 16 that there has been a significant shift and the needs of 17 the resident doctor, for example, I think you say in 18 your statement may vary considerably from one to the 19 next and the idea of having a sort of "one size fits 20 all" model is very much the opposite of the approach 21 I think you would take; is that correct? 22 A. That would be correct. 23 Q. Just in terms of the types of training that are 24 delivered, to be clear -- and again, I'm afraid 25 I'll have to put it into a surgical context because Page 142	1 on the emphasis on the non-technical skills because what 2 we know is that somebody can be technically extremely 3 proficient but if they don't create a culture around 4 them of curiosity, challenge, safe enquiry, then 5 actually that's not a safe environment, either for 6 patients to receive care or for resident doctors to 7 train. So we see that as really, really critical in the 8 training. 9 Q. Thank you. One aspect that's been emphasised by 10 a number of witnesses so far as being a very important 11 part, certainly to patients, of medical care is the 12 importance of keeping and retaining good medical 13 records. I could imagine that that could be the sort of 14 thing that's thought of as an accessory to actual 15 medical practice. Is that the sort of thing you deliver 16 training in, or help facilitate training in? 17 A. So the keeping of good records is a core professional 18 competence that I would expect every doctor to not only 19 be taught but to receive feedback on and review. And 20 the adage that our handwriting can be quite poor is no 21 excuse to maintaining clear, dated, signed records that 22 are easy to see by others and we emphasise that 23 throughout the training journey. 24 THE CHAIR: Where does that feedback come from, if you don't 25 mind my asking? Page 144

1 A. So particularly for resident doctors in training, that 2 will come from their clinical supervisor or supervising 3 clinician or from other colleagues that they work with. 4 And I don't want to say something is very poor practice, 5 but the notes that we keep, we have a duty that they are 6 legible, easy to read, making clear descriptions of our 7 assessment of the patient and our diagnosis, treatment 8 plan, and that they are timed, dated and signed. And 9 that is something that we do teach our resident doctors, 10 both from undergraduate all the way through. 11 MR DAWSON: Thank you for that. One other aspect that may 12 have some significance in our Inquiry is the extent to 13 which people who arrive at the beginning of the process 14 that you've described -- and you talked about maybe 15 a sort of classical journey of being educated within the 16 United Kingdom, getting the MBChB and moving to later 17 stages -- and you did, I think, mention people going out 18 or back in and gaining -- people coming in at different 19 levels of experience. 20 One aspect of which is of interest to us that 21 I would be interested to understand from you is the 22 extent to which people who have acquired medical 23 qualifications in other places, other countries, other 24 systems, how the medical education that's delivered now 25 seeks to assist those resident doctors. So, for Page 145	1 doctors in training who come to the UK from overseas. 2 So we have programmes of lengthy induction where their 3 clinical practice can be supervised so that we can 4 ensure they are at the standard that we expect. And for 5 the majority they are but for a very small minority they 6 are not and at that point we intervene with educational 7 interventions, perhaps placing them in a different 8 environment and supporting them to learn the skills that 9 they need to deliver safe patient care. 10 Q. On the first part of that -- so the support part you've 11 mentioned there, but the first part which is to get some 12 sort of indication as to what level in the training 13 journey they reached and some sort of certification from 14 a medical professional, their supervisor or you said of 15 a certain standing, is that a process that you're doing 16 or is it the GMC, or are you just trying to work out 17 where they fit into the journey here? 18 A. So medical recruitment for resident doctors in training 19 is delivered for the UK by NHS England and they've got 20 specific systems in play to support the gathering of 21 that information and the checking and we can provide 22 further detail of that to the Inquiry if it's helpful. 23 Q. That would be very interesting to us, thank you for 24 that. I have a few more questions for you on the 25 subject of some helpful evidence you have been able to Page 147
1 example, if they've done their undergraduate degree 2 somewhere else or they've perhaps done a certain element 3 of training somewhere else and wished to join the 4 training system here, is that something that your 5 organisation is involved in to some extent? And what 6 steps can be taken to do that? Because it is, I think, 7 from the sophisticated systems that exist, very 8 important that certain standards are met such that 9 someone progresses as appropriate through the system and 10 fitting in conceptions of things that have arisen from 11 other areas maybe make that more difficult. 12 I'm interested in your reflections on that. 13 A. So for resident doctors in training, we do recruit some 14 resident doctors in training from overseas. Not all 15 overseas medical degrees are recognised by the GMC, so 16 the GMC have certain standards that they hold overseas 17 medical schools to, to be able to say the doctor is 18 eligible to be registered by the GMC in the UK. So 19 that's one of the first safeguards. 20 The second safeguard is that we, when recruiting 21 doctors from overseas, ask for evidence of where they 22 are in their training journey and that they have that 23 signed off by a supervisor who has a recognised 24 qualification and a certain standing. 25 The next element would be how we support resident Page 146	1 provide, no doubt looking in the archives, about 2 Mr Eljamel himself. I wonder if we can go back to the 3 statement, please. Paragraph 13.1. We'll read this out 4 in a second but this is a context in which we're asking 5 questions about whether you have -- you can give us 6 a broad chronology of the involvement of NHS Education 7 for Scotland or the predecessor body with Mr Eljamel and 8 I'm aware you've conducted a search and we talked about 9 the searches earlier and the assumptions made about the 10 record retention policy. But one thing that comes up in 11 this paragraph is that because of the role that he was 12 playing, it's a safe assumption, isn't it, even if 13 there's no record, that Mr Eljamel was a clinical and/or 14 educational supervisor as he was a consultant and there 15 were very few consultants in the unit? 16 A. Yes, that would be right. 17 Q. Yes, thank you. So just to give some context. What you 18 tell us here: 19 "NES have no knowledge of NES or its predecessor 20 bodies being involved with, or aware of, the 21 professional practice of Mr Eljamel. To the best of our 22 knowledge, Mr Eljamel would have held Supervisor roles 23 and would have needed to complete the required training. 24 Due to our record retention policy ... we no longer hold 25 any documentation in relation to any training undertaken Page 148

1 by Mr Eljamel. We know he stepped down in July 2012 but 2 cannot confirm when he commenced these roles. 3 And then just moving forward to a later paragraph 4 you tell us, in paragraph 20.5, please: 5 "Mr Eljamel served as an approved Educational and 6 Clinical Supervisor for Resident Doctors in Training 7 with NHS Tayside until July 2012. Accordingly, it was 8 expected that NHS Tayside would verify his competency 9 for this position and promptly escalate any concerns to 10 NES should they arise. No concerns were ever raised 11 with NES. NES do not hold any documentation in relation 12 to this appointment as the appointment would have been 13 made by Mr Eljamel's employer. 14 "Mr Eljamel stopped being a Supervisor in 2012. NES 15 are not aware if this was due to suspension or not. As 16 explained above, NES do not assign the supervisors to 17 the RDiT [resident doctors in training] as this is 18 managed by the Health Board. 19 "It would be inappropriate for a suspended doctor to 20 continue in any capacity as a clinical or educational 21 supervisor." 22 Now, just to work this out. So you have helpfully 23 deduced, in the first instance, that he must have been, 24 because of the role he had, an educational, probably and 25 clinical supervisor, not necessarily to the same person, Page 149	1 A. So my understanding is that the directors of medical 2 education in the health board upload the list of 3 educational and clinical supervisors to our data base. 4 Doctors appear and come off that database and it would 5 be unusual for us to have a reason given for that. It 6 could be that they have taken on another role and don't 7 have the capacity or time in the job plan to do the 8 role. It could be a matter that's been decided in the 9 clinical department that that person is not to continue 10 in that role. 11 Q. I see. I don't know whether we've seen that record but 12 we would like to see it. I'm sure it will contain names 13 of other people but obviously we have systems to make 14 sure that their names which are not relevant for our 15 purposes wouldn't be displayed or anything like that. 16 So that would be very useful to see. 17 THE CHAIR: Sorry, Professor, can I just double-check with 18 you who it was you said would be responsible, or at 19 least you would expect to upload to your database? Did 20 I understand you to say the director of education? 21 A. The director of medical education. 22 THE CHAIR: Medical education in the health board. 23 A. Yes. 24 THE CHAIR: Thank you. 25 MR DAWSON: Is that part of the department of medical Page 151
1 as we've discussed; is that right? 2 A. That is my understanding. 3 Q. And you've also told us that he stopped being 4 an educational and clinical supervisor for resident 5 doctors in training in July 2012, is that right? 6 A. That is my understanding. 7 Q. How do you know that? 8 A. So -- and I have asked my team to clarify this for me. 9 We have a record of who are the educational and clinical 10 supervisors and he stopped being on that record 11 in July 2012. 12 Q. Okay, because you speculate -- helpfully, I don't mean 13 to be critical -- that this may be connected with his 14 suspension, but that happened later than that. So 15 the July 2012 date derives from your records but does he 16 just not appear on it again, is that what happens? 17 A. That's right, he's removed from the record as 18 an educational supervisor. 19 Q. So, you do still have a record of that, but you did you 20 manage to find any records as to why that might have 21 happened at that time? 22 A. No, unfortunately not. 23 Q. But would he have had to -- what would the system have 24 been for him to have appeared on that, would he have had 25 to have been reregistered every year, or ...? Page 150	1 education, or is that something different? 2 A. So each health board has a medical education structure 3 that has a director of medical education who works to 4 the medical director to ensure that there are standards 5 supporting the delivery of medical education in that 6 board, including the appointment of educational and 7 clinical supervisors, but also ensuring that the 8 resident doctors in training have the right induction, 9 the right access to learning environments, have their 10 educational needs met and they're a really important 11 part of that educational and governance system in the 12 boards. 13 Q. Okay. That's someone I assume that your organisation 14 would liaise with frequently? 15 A. Yes. 16 THE CHAIR: Sorry, that's a medical practitioner? 17 A. It's a medical practitioner. 18 MR DAWSON: Just going back to the previous page, please, 19 paragraph 20.1. You say there -- again, this is under 20 "conclusions" section: 21 "To the best of our knowledge, NES and its 22 predecessor bodies were not informed of any concerns or 23 challenges regarding Mr Eljamel's professional conduct 24 from Resident Doctors in Training, Educators, NHS staff, 25 or NHS Tayside. Established protocols existed at the Page 152

1 time for reporting such matters, and NES would have 2 responded appropriately had any issues been brought to 3 its attention." 4 So just on, first of all, the first part about no 5 reports having been made, that you repeat several times 6 is based on the documentation that you've been able to 7 access? 8 A. That's correct. 9 Q. It's possible, of course, and you've helpfully provided 10 us with the identity of some individuals who might have 11 been around near the time that could help us with that, 12 but that's just based on that assessment? 13 A. That's right. 14 Q. And the part at the end when you say "NES would have 15 responded appropriately", is an assumption on your part? 16 A. Umm, so, it's an assumption but based on a knowledge of 17 how NHS Education for Scotland did have systems and 18 processes in place where they did undertake visits and 19 reviews when concerns were raised with them. 20 Q. But I'm just trying to clarify that you don't have any 21 evidence of the first part and you don't have any 22 evidence of the second part either. You're assuming it 23 based on your knowledge of the systems? 24 A. Yes, I don't have any documented evidence. 25 Q. Thank you. And in paragraph 20.2, it says: Page 153	1 Q. That might be a safe assumption then? 2 A. But it might be a safe assumption. 3 Q. Right, but as to how he actually held that post for that 4 year? 5 A. So we have got -- so, I have been informed by my team 6 that they have got evidence that he was a facilitator on 7 the Scots course between 2009 and 2010. 8 Q. Again, it would be useful to see that. It may be 9 something similar to the log or whatever register we saw 10 earlier, but that would be helpful. Just in terms of 11 what that is, I'm assuming that that is -- because of 12 the educational supervisor is appointed locally, they 13 would run courses to be able to make sure that people 14 are able to perform the function properly, but I think 15 did you not tell us earlier that NHS Education for 16 Scotland also provides courses for the supervisors and 17 that was their limited function with them? 18 A. So at the time, the Scots courses were written by 19 colleagues working within NHS Education for Scotland and 20 some were delivered by educational faculty from NHS 21 Education for Scotland. There were some local delivery 22 of courses that were either done in collaboration with 23 colleagues from NHS Education for Scotland or by faculty 24 from within the health boards but to the educational 25 product that was developed by NHS Education for Page 155
1 "In 2009, Health Boards in Scotland were contacted 2 by NHS Education for Scotland (NES) to identify 3 Consultants capable of facilitating local Educational 4 Supervisor courses provided by NES. NHS Tayside 5 recommended Mr Eljamel as a facilitator to run the 6 course. Subsequently, he served as a facilitator for 7 this course during the period 2009-2010. Unfortunately, 8 due to the NES retention policy ... there is no 9 documentation available in relation to this. It would 10 have been our expectation that NHS Tayside had no 11 reservations regarding his role in delivering this 12 course and would have escalated any concerns to us if 13 they had arisen. No concerns were ever raised regarding 14 the delivery of these courses by Mr Eljamel and others." 15 Again, similar to the other part, how is it that you 16 know that NHS Tayside recommended Mr Eljamel and how is 17 it you know that he served as the facilitator over that 18 year? 19 A. So in terms of knowing it was NHS Tayside who 20 recommended Mr Eljamel, that that will be based on -- 21 that is the board that he was working in and the NHS 22 Education for Scotland went to individual boards to 23 provide local faculty to deliver that course. So 24 I don't believe I have any written or documented 25 evidence for that, but -- Page 154	1 Scotland. 2 Q. So just the use of the word "facilitator", I suppose 3 I'm trying to work out, is that someone who liaises with 4 NHS Education for Scotland or actually delivers the 5 course, or -- 6 A. So my understanding of that term is that the facilitator 7 would have been an active participant in delivering the 8 course. They wouldn't have been the sole deliverer. 9 Q. And as I understand the role of educational supervisor, 10 that would be potentially across, is that the whole 11 hospital or the whole board? Because there would be 12 educational supervisors required in every department? 13 A. Yes. So it would be around the generic skills that you 14 would expect the educational supervisor or clinical 15 supervisor to have and what evidence they would be 16 looking for. I can't speak to the technical aspects of 17 the Scots course. 18 Q. Right. Do you think -- well, I know a lot of the 19 documentation doesn't exist, but are there documents, do 20 you think, that would tell us what the Scots course -- 21 or some more detail about that? It's the Scots course 22 we're talking about, I assume? 23 A. Yes, we can find out if we still have examples of that. 24 Q. Yes, it would be very helpful to know. In particular 25 the sorts of people who might have been receiving that Page 156

1 training, that would be very useful to know. Those are 2 all the questions that I have for you. Thank you. 3 THE CHAIR: I have one point, Mr Dawson. On this -- and 4 again, the absence of documentation may mean that you 5 can't answer or can't answer specifically in relation to 6 Mr Eljamel -- but I note from paragraph 20.2, that this 7 proceeded, or appears to have proceeded, on 8 a recommendation of the relevant health board. Is that 9 a recommendation that would, as a matter of course, be 10 checked or would it simply be accepted? 11 A. I wasn't working with NHS Education for Scotland then 12 and I don't know what their processes would have been, 13 I'm sorry. 14 THE CHAIR: All right, thank you. 15 MR DAWSON: Would it be now? 16 A. So now, in terms of recruiting faculty to deliver, 17 I would need to go back and check what our protocols 18 are. 19 Q. We would be very much obliged if you do so. Those are 20 all the questions I have with you. What happens now is 21 we have a very short break where we ask our core 22 participants if they have any further questions. So, 23 thank you. 24 THE CHAIR: Do you want to ask the witness if she has 25 anything that she wants to add? Page 157	1 materials for this Inquiry, is the importance of 2 ensuring information relevant to patient safety, doctor 3 and training safety, professional practice, is 4 recognised, acted on, but importantly, connected. 5 The system today is more formalised and better 6 connected but improvement is a continuous process and 7 I think there might be real value in strengthening the 8 integration between clinical and educational governance 9 to support earlier recognition to achieve an even safer 10 connected system for our patients. Thank you. 11 MR DAWSON: Thank you. 12 THE CHAIR: Thank you. Anything you want to follow up on? 13 MR DAWSON: Nothing to follow up, sir. 14 THE CHAIR: All right, we'll take a short break while we 15 check whether there are any remaining questions, so if 16 I can ask you to go with Ms Miller back to the witness 17 room we'll resume again shortly. Thank you. 18 (4.19 pm) 19 (A short break) 20 (4.26 pm) 21 THE CHAIR: Thank you. Mr Dawson. 22 MR DAWSON: Thank you, sir. There are, in fact, no further 23 questions from the core participants. Thank you very 24 much. 25 THE CHAIR: Thank you very much. Professor, thank you very Page 159
1 MR DAWSON: Yes, sorry. I usually, at this stage, ask 2 witnesses whether there is anything they'd like to add, 3 so I'd ask you that? 4 A. Would that be okay? 5 Q. Yes, absolutely. Of course, please. 6 A. So I would like to make a reflection and it's 7 particularly about an area that you highlighted earlier 8 in that interplay between educational and clinical 9 governance. And much of my evidence this afternoon has 10 been about educational governance and the role of NHS 11 Education for Scotland. And one of my reflections is 12 that educational governance should not be viewed solely 13 as a mechanism for assessing resident doctor in training 14 safety and training quality. I think it forms 15 an important part of the wider patient safety 16 architecture. 17 Resident doctors in training work at the front line 18 of care every day, they experience supervision, culture, 19 workload, behaviours and the realities of clinical 20 practice and they can provide an important early warning 21 signal about risks in the system. 22 Educational and clinical governance have different 23 responsibilities but they are looking at the same 24 clinical environment through a different lens. 25 One of the lessons for me, in reviewing the Page 158	1 much. You will just have gathered that that brings your 2 evidence to an end. And just before you go, can 3 I extend the Inquiry's thanks, and indeed my personal 4 thanks, for you attending the hearing suite today to 5 give evidence and indeed for the work that's obviously 6 gone into preparing this statement and associated 7 materials. It's much appreciated. As is also your kind 8 offer to submit any further materials. If there's any 9 dubiety about what we were looking for, no doubt that 10 can be dealt with in correspondence. But with those 11 thanks having been extended, you're free to go. 12 A. Thank you so much. 13 MR DAWSON: No further witnesses for today, sir. 14 THE CHAIR: All right, thank you. 15 (4.27 pm) 16 (The hearing adjourned until 10.00 am on Friday, 17 11 September 2026) 18 19 20 21 22 23 24 25 Page 160

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