Thursday, 10 September 2026
(10.00 am)
(Proceedings delayed)
(10.09 am)
THE CHAIR: Good morning, please have a seat.
Mr Dawson, good morning.
MR DAWSON: Good morning, sir. The first witness this morning is Karen Titchener.
THE CHAIR: Thank you.
MS KAREN TITCHENER (sworn)
Questions by COUNSEL TO THE INQUIRY
MR DAWSON: Good morning. You are Karen Titchener?
A. I am.
Q. And you are the Patient Safety Commissioner for Scotland?
A. I am.
Q. Could I just ask you, Mrs Titchener, when you're giving your evidence to try to speak into the microphones in front of you, they're a little tricky, just so everyone can hear what you're saying. Just one other thing I want to make clear to you, I know from your written evidence you have had some contact with patients who are, some of them I think, core participants in this Inquiry or otherwise. For present purposes the Inquiry is avoiding mentioning the name of any patients for

confidentiality reasons other than two patients, one of whom I think you have had contact with, it's Jules Rose and the other who you may have had contact with is another individual called Pat Kelly. So if you feel, in answer to any of the questions that you wish to refer to patients, if you could otherwise try to respect their anonymity other than those two names I'd be most grateful. You could, of course, provide those names if necessary to the Inquiry afterwards outwith this session.
A. Thank you.
Q. You provided a witness statement dated 13 July this year; is that correct?
A. That's correct.
Q. Could we have that up on the screen please, it's PSC-00001. Is that your statement?
A. Yes.
Q. Could we go to page 29, please, and although it's blanked out does your signature appear on that page?
A. It does.
Q. And are the contents of this statement true?
A. True.
Q. Thank you. As you have said, you're the patient -- just go back to the front you page of the statement, thank you very much. Thank you. You're the patient safety

commissioner. I understand you commenced in the role on 1 September 2025?
A. That's correct.
Q. And it's a full-time post, yes?
A. It is.
Q. You have a background, I think, in nursing?
A. That's correct.
Q. You are a registered general nurse and advance nurse practitioner?
A. Yes.
Q. But you don't practice as a nurse, given your full-time responsibilities in the other role?
A. That's correct.
Q. What is an advance nurse practitioner?
A. It's an extended qualification at a master's level, sometimes it's done at a doctorate level, but it's to -- so that you're practising at a different level. So you learn advanced -- you learn physical assessment, you learn anatomy and physiology and you're prescribing so that you can work alongside doctors but still not called a doctor but you are still allowed to diagnose and prescribe.
Q. I see, so it's a higher level of qualification for nurses which, as you advance through your career, you might wish to try to achieve; is that right?

A. Yes, yes.
Q. Does it require examinations being sat?
A. Yes, it's a full -- there's OSCEs and all sorts of things and then obviously then written -- much written work and a dissertation to round up the masters.
Q. I see, and if you reach that level it would enable you to carry out more complex functions in your nursing role?
A. That's correct.
Q. I see, thank you.
A. You can -- you're an individual practitioner working within your licence of your expertise.
Q. Understood, thank you. In your career before taking up the current post I understand that your career, at least latterly, focused on health at home programmes, is that right?
A. That's correct.
Q. Could you tell us a more about that, what they are and what your role in connection with them involved?
A. Yes. So back at the turn of the century actually there was an NSF for older people, the right care in the right place at the right time for the right people. And that said there's a lot of care that's happening in hospital that with the right expertise in the home that could be given at home. So even then it was looking at bed

capacity and looking at A&E waits and things like that and thinking how could we stop that care hitting hospital.

So I have been involved in building programmes, both admission avoidance and early discharge and that's a multidisciplinary team including GPs, geriatricians, nurses, physiotherapists, pharmacists and it's basically taking patients on to a programme that's step-up care or step-down care from their usual care. So if they had hit the emergency -- the A&E you'd be taking them out to give that care that may have happened in a hospital bed. If it's from a GP and they're wanting to refer them to the hospital, again you could step in and give that care. So it's a higher level care than normal community nursing care would be giving and for a very short period of time.

Q. Right. You mentioned there being an impetus behind that to do with capacity of beds in hospitals but presumably the systems are designed to try to promote the therapeutic advantages to individuals of being at home rather than in hospital, no?

A. Yes, but I'm not sure that concept has totally embedded because, you know, when patients are heading to hospital they know that they're not very well and their expectation is potentially that that care will be

happening in hospital. So I think more recently it's becoming more acceptable. I think people feel that if they're getting care at home it's lesser care than they would get in hospital but we know, particularly with older people, the care that they get in hospital they usually end up decompensating and, you know, becoming less mobile because they take on the role of the patient, and they sit in the chair and they don't go and get their cup of tea.

So I think it's becoming more acceptable certainly but I would still say it's not the course of least resistance, the course of least resistance is still to admit the patient.

Q. Do such programmes only involve certain types of patients?

A. So in Scotland they have chosen for it to be care of the elderly. So care of the elderly physicians would be leading that and frailty, but elsewhere in England, when I did the programme in London, that was for over 18 so it was for anybody. So, and again, that was to reduce bed capacity and we had targets to hit so many patients to try and relieve the pressures.

Q. Understood. Obviously in this Inquiry we're predominantly interested in the field of neurosurgery. That tends to involve people who are in quite serious

conditions. Would such programmes be suitable for those individuals?

A. No. If somebody has a stroke or, you know, has got something going on neurologically there would be other programmes they would be referred to following their discharge. But this isn't about depriving people of the appropriate care, it's about providing care that could otherwise happen at home.

Q. Thank you. In your broader experience in the nursing profession do you have any experience of working in hospital surgical settings?

A. No.

Q. Is it correct to say that before taking up your current position you hadn't previously worked in Scotland?

A. That's correct.

Q. Has, in your -- I understand that you've been in the role for about a year now and we'll look at this in a bit more detail in a moment, that's involved quite a lot of setting up the arrangements for the post to be able to be delivered properly; is that correct?

A. That's correct.

Q. Because you're the first person to hold this position in Scotland?

A. Yes.

Q. How have you found the fact that you didn't previously

work in Scotland in the role so far, in particular with regard to the possible disadvantages of not knowing the Scottish system but the possible advantages of coming to it with a fresher perspective?

A. So I think both of those are true. I think I had to very quickly understand NHS Scotland which was very different to NHS England, I had to understand obviously the health system and the boards but I was equally able to come with fresh eyes and think: oh, I wonder why you're doing that. So I think it was a positive as well as a negative and I never see anything as a negative anyway, I just had to learn quicker than I would have had if I had been around in Scotland. And remember, there's no footprint for this so it's -- you're walking on fresh snow every day. You've got an act but you're having to decide yourself how you're going to build the programme.

Q. Absolutely. And that process of learning about the way that the systems are organised in NHS Scotland is very much a process in which we're involved ourselves. So have there been any -- from your perspective of patient safety, have there been any features of that organisational structure which have struck you as particularly conducive towards maximising patient safety or perhaps potentially problematic in that regard?

A. I think -- I think Scotland is improvement-rich but assurance -- there's a gap, I think, between independent assurance and that improvement arm that has happened. I think there are many organisations out there that are attempting to improve things. I think there are things that could make it better, you know, regulatory bodies that -- Scotland doesn't have a QCC, for example, the quality care commission that England has. It does have Healthcare Improvement Scotland which is -- for the NHS is an inspector not a regulator.

Q. So as I understand it, you'll correct me if I'm wrong, the quality care commission in England would have a function in the oversight and regulation of healthcare providers; is that correct?

A. No.

Q. No. Explain to me the difference.

A. Sorry, so it is -- it does inspections of hospitals and -- but it has more power behind it to then enforce the output.

Q. In what way? How would that work?

A. So it's got regulatory powers. So it can prosecute, it can -- obviously it tries to get people to change, as does Healthcare Improvement Scotland because obviously when they do an inspection they give recommendations. I think those recommendations are recommendations and

there's no mandatory or statutory power for that to be enforced.

Q. So is that what you mean by the culture being improvement-rich but independent assurance poor perhaps that you have bodies like Healthcare Improvement Scotland that are perhaps doing good work, investigating things, creating recommendations, but when you get to the point of those having to be enforced that's where there's perhaps at least a difference with England or perhaps a lacuna in the system?

A. Yes.

Q. Thank you. That's something which we will be exploring with other witnesses more directly involved in that field but that's very helpful. And do you think that that lacuna that you've identified or that difference has an effect on patient safety?

A. I think it has the potential to have. I haven't got evidence of that but it's just something that I have in my head, so please understand this as my perspective.

Q. Yes. Of course.

A. So I have to look at the areas out there that I'm concerned about and that -- you know, that we need to change so that was one of the areas I had been thinking about.

Q. Organisationally speaking, you've told us that you've

been learning about the organisation of the delivery of healthcare in Scotland and no doubt, just as you've done so, there appears to have been a major change announced to that. Last week it was announced that the 14 territorial health boards would effectively, as I understand it, be disbanded and moving to a two health board system. First of all, is there anything you can -- do you have an understanding of how that's going to work? Is that something you've been told about?

A. I have no idea how it's going to work. I think it was announced but with no footprint as to how that is going to work.

Q. Yes, as a policy if you like but perhaps it needs to be worked through. But in trying to think about this I thought it was probably unlikely to have an effect on your role, given where you sit, but do you think it is likely to have an effect on your role?

A. Well, I will certainly be -- I have concerns that going from 14 to two, or I think it's actually 11 to two and then the islands are potentially going to be boards as well so it will be three boards, but for me it's around -- you know, I'm the Patient Safety Commissioner for Scotland. So I need to make sure that whatever changes are happening it doesn't increase the risk to patients. So therefore I will want to be watching very

carefully the decisions that are being made and make sure that the patient -- it's patient-centric because this shouldn't be all about money, this should be about providing better and safer care. So I want to make sure with -- I don't know how I will -- I'm not sure I'll be involved in the decision-making but I certainly -- from our office we will be amplifying the voice of the patient where there's concerns raised.

Q. Thank you. Is it your perception at the moment that it's all about money?

A. I don't know. That's what's it's being presented as but it has to be -- it has to be about more than that.

Q. Thank you. Because you've helpfully pointed out, that was my understanding too, that there will be a third health board if you like for the islands. Inherent in that announcement seems to be a recognition that the geographical, perhaps other considerations, related to the islands needs to be treated differently but I think it's been voiced politically already there are some concerns about having a two-board structure on the mainland, if you like, would appropriately reflect the local requirements of patients in different parts of Scotland. Is that a consideration that you think you will take a keen interest in?

A. Yes, I mean I think there's already inequities of care

in rural areas in Scotland, not just in the islands. So again, I think we have to make sure in whatever decisions we're making and centralising things that that doesn't mean that care is going to be provided further away from people's home.

Q. Because the geographical area that's covered by any healthcare provider can stretch it, can make it less patient-centric, can make it less efficient. Is that a phenomenon that you're familiar with?

A. Yes.

Q. Thank you. I understand -- to talk a bit more about the role itself, thank you for that. I understand that the role was created, albeit it came about quite a lot later, as a result or in response to the independent medicines and medical devices safety review, commonly called the Cumberlege review, is that right?

A. That's correct.

Q. And it reported in 2020?

A. Yes.

Q. And the reference we've given to the document that you've provided is PSC-00007 and in that review, as I understand it, it was found that patients' concerns in the matters they were looking at had often been ignored or dismissed; is that right?

A. That's correct.

Q. And in fact, in the circumstances of that Inquiry, that this had in fact led to avoidable harm and systemic failure?

A. Yes.

Q. The focus of that Inquiry was on medical devices of various different types, I think?

A. Yes. It was medicines and medical devices because those were the -- both sodium valproate and the pelvic mesh were the two big things that came out in that.

Q. Yes, and you say -- just to be clear, the ultimate position that you now hold isn't limited to those sorts of considerations, medicines or medical devices, it is a broader remit, isn't it?

A. That's correct, it is a much broader remit.

Q. So in case anyone misunderstood although the post came out of an inquiry related to a more specific subject matter, the recommendation was for a patient safety commissioner that would cover patient safety across the board?

A. Yes.

Q. And that is what, in fact, has been created and the role you now occupy?

A. Yes.

Q. You say at paragraph 3.10 of your report -- if we just go to that.

A. Yes.

Q. Just zoom in a bit on 3.10, thank you. It says:

"Scotland committed by way of the Programme for Government 2020 ... to establishing a national patient advocate. Therefore, the role was created to strengthen the patient voice and provide independent scrutiny of safety addressing system-wide failures rather than isolated incidences."

How does your role provide independent scrutiny of safety with a focus on system-wide failures as opposed to isolated incidences?

A. Yes, and that's what differentiates this office from the Ombudsman because the Ombudsman in Scotland looks after individual cases, so I think that's why they were trying to separate it out. So the office is there to hear the voice of the patients and when -- obviously patient complaints have to follow the due process, so you know, go to the board, go to the Ombudsman but when patients are writing to us if we think it is something systemic, on when other processes are going on, we will still start our process of looking to see. And if I'm honest most patient complaints are never about an individual person or an individual thing, so actually you could say most things that patients are talking about are to do with system level.

Q. We'll return to that very important theme in a moment, Mrs Titchener.

THE CHAIR: Mr Dawson, can I clarify one point, I think you said it but I wanted to check I didn't misunderstand it. If a patient wishes to approach you with a complaint of whatever kind, it is not a pre-condition of their doing so that they should have been through a complaints process already to the point of resolution?

A. It is. We encourage people -- so, often if it is looking like it's an individual complaint, you know -- I don't want to give an example, but if it's an individual thing then we make sure that they have done that complaint to the board. But even if it's a system thing, we still want the board to be aware that the patient has got that complaint.

But what is happening at the minute is because there is a delay in -- so boards might say: we can't get back to you for nine months, I think the Ombudsman as well are very, very busy. And so if they're saying: we can't get back to you and patients are feeling like it's a now issue, then that's when we would get involved because we don't want to wait nine months. If somebody turned up to an A&E and there were no oxygen masks, you know, I'm not going to wait for the board to do that investigation.

THE CHAIR: Thank you.
MR DAWSON: For the sake of clarity, the Ombudsman you mentioned earlier is the Scottish Public Services Ombudsman.
A. Yes.
Q. You mentioned earlier an interesting point that quite often, in reality, what might appear to a patient to be an individual complaint actually involves systemic matters but they may well not know that, is that right?
A. Yes, the patient may not realise. But also even if it's not, it still adds to our story to look at systemic because it's like: oh, that's another patient from, you know, who is saying something about that department. So even though it may be, on the surface, an individual complaint it could add to the picture of actually is there something going on systemically. So we always have to look at that.
Q. Indeed. You may have answered my very next question which was to be how -- given the systemic focus of what you do, given the fact as you have explained to the Chair individual patients can approach you directly, how you would translate, if you like, an individual complaint into something systemic and therefore falling within your remit?
A. Yes, so as you know there's a complicated Act for the

Patient Safety Commissioner. So now that I have an officer for it, we are putting together a framework of how we address complaints when they come in. So is this just an informal approach or, as the Act says, do we need to do something more formal with this. So we're putting together a framework, a legal framework to make sure that our office is acting within the framework of the Act of the Patient Safety Commissioner.
Q. I see, but is it then within your discretion, if you like, to decide how you go about translating the individual experience into something systemic? Because obviously you've got to work within the systemic remit but how that actually manifests itself, is that a meter for you to determine?
A. Yes, so within the framework we're looking at triggers of escalation. So is this just something I want to talk to the board about in an informal way or -- whoever the complaints come in, I'm using boards as a generality.
Q. Of course.
A. Or is this something actually that's very serious and we need to then trigger an investigation.
Q. Because there's two aspects that I'd like to explore with you, the first of which is a phenomenon, I think, that we have heard evidence about in this Inquiry and indeed as I understand it is a phenomenon that's been

present in other similar Inquiries which is the belief on the part of an individual where they are dissatisfied with their care or something has gone wrong or they've suffered an adverse outcome, that they are the only one who has been affected this way, whereas in reality there are other people feeling exactly the same way. That is a common phenomenon where groups of patients come together, as I understand it was the case with patients here, but is your office, whether at the moment or once the framework is set up, is part of its function to try to join those people together or join the dots together of their experiences to try to recognise that there may be something systemic going on here?
A. 100%.
Q. Yeah. The other aspect of this that I wanted to address is something you touched on yourself, I think you mentioned the words a "now" issue because I wanted to raise with you the possibility -- and again I think this is also the experience of patients in this Inquiry and in other similar ones -- that there is a danger that that process, even with the assistance of someone in your office, can take a long time. So it may be to build up the pictures and join the dots, that that could take a long time. Is that possibility and that danger something that you're conscious of?

A. Very.
Q. And what -- at least at the moment as you're formulating your framework, what is your thinking around what you can try to do to try to accelerate that process?
A. You know, I think, you know we are a small office so for us to be firefighting every "now" emergency or patient safety risk that happens, I'm not sure what we could do for that. So I think this is about all the systems that are working together. You know, we've got Healthcare Improvement Scotland and I don't want to talk about what they do but they have turnaround, they can go in and help people. If a board is struggling, they can do -- they can go in and help but I'm sure you'll hear more from them now and they'll say I don't know what I was talking about. So for us I think, if it is literally something that I feel is of imminent danger to a patient, I would be pick picking up the phone to the board there and then to escalate that and if I needed to, escalate it to Scottish Government or/and HIS.
Q. Because one other aspect of the timing aspect of the "now" issue that I wanted to raise with you -- I'm slightly loathe to delve too far into the Act because it is a complicated framework, as you have said and involves a lot of practical steps that you have been, I think, occupied with over the last year or so

but there are some aspects that I think are worth highlighting and are interesting to explore with you. If we could have a look at that please, ELJ-00559. This is the Patient Safety Commissioner for Scotland Act, which is the statute which creates your office, isn't it?

A. That's correct.

Q. And in section 2 it sets out that:

"The Commissioner's general functions are.

" ... to advocate for systemic improvement in the safety of health care, and.

" ... to promote the importance of the views of patients and other members of the public in relation to the safety of health care.

" ... In exercising [these] functions, the Commissioner may in particular.

" ... gather information, for example patient feedback, relating to the safety of health care.

" ... keep under review, analyse and report on information obtained."

And over the page:

" ... make recommendations for systemic improvements in the safety of health care.

" ... promote public awareness of safety practices in relation to health care.

" ... promote co-ordination among health care providers and public authorities with functions that relate to health care."

And Section (3), it states -- which is the bit I'd like to focus on for present purposes:

"It is not the Commissioner's role to resolve, or facilitate the resolution of, grievances arising from past incidents; accordingly, the Commissioner has no power to.

"... make awards, or provide other form of redress, for harms suffered.

"... assist individuals in seeking redress for harms suffered.

" ... [or] opine on the action that another person ought to take in respect of an individual in light of a past incident."

We'll probably talk about some of the other component parts but just as we're on the timing aspect, the subsection (3) imposes, no doubt very deliberately, on part of the legislature prohibition, if you like, on you looking into past incidents. So your role is very much a forward-facing one, is that right?

A. That's correct.

Q. It is, however, I think, possible for you to take cognisance of past incidents insofar as those past

incidents may inform the improvement of the safety of healthcare in the future?

A. Yes.

Q. So, is that right?

A. Yes.

Q. Yes, so you have the ability to look at -- as we are -- past incidents in order to try to work out whether that might help you make recommendations to better healthcare in the future?

A. Yes.

Q. Thank you.

A. I think this relates to -- because obviously everybody who talks to me, it's in the past.

Q. Of course.

A. So I think this was potentially talking about the redress and things like that for the sodium valproate and the mesh, of which I happily support the people but it's not my role to fight for the redress.

Q. Yes. It's to make clear, I think, that there are limits on what it is your role should rightly do so as to allow you to focus on particular areas and therefore do the best job possible in those areas?

A. Yes, but also we have to learn from past failings and therefore you have to look back to address the future.

Q. Thank you. Another feature of your role which you have

emphasised and is apparent from the Act, one can see, if we go back to the statement, please, paragraph 3.22, this is the importance of independence. And it says there, you say there:

"The need for independence also flows directly from the role's origin. The Cumberlege Review found that patients had repeatedly raised legitimate safety concerns that were not heard or acted upon by the organisations responsible for their care. An office that sits within, or is answerable to, those same organisations cannot credibly fulfil the function of amplifying patient voices and holding systems to account. Independence is the condition that makes the role trustworthy to the public it serves."

Now, we could probably spend the rest of the day analysing aspects of that, particularly in the context of how this Inquiry came about, but obviously the role and -- the role grew out of evidence heard and accepted by the Cumberlege Review, but can you tell me, in terms of how you've interpreted your role, how important independence is to it?

A. I am -- I guard it with my life, my independence. It's very, very important because I have no skin in the game around any person who has -- when harm has happened to patients. So I think it's very important that I'm not

answerable to Scottish Government, I'm answerable to boards or to HIS. Once a year I write a report to parliament, but I think in order to advocate for the patients it's fundamentally essential to this office that we remain independent.

Q. And again, there's a resonance of aspects of that paragraph in what evidence we have heard here and aspects that we are examining that it has been, I think, that the origin of your office, as I understand it, flows to an extent from previous experience of others who have tried to have issues investigated but when they have had those investigated within, or within bodies associated with the body into whom the investigation -- into which the investigation was taking place, have ultimately been dissatisfied with the outcome being under the impression, as they were, that that was not a properly independent investigation. Is that an understanding of -- is that your understanding of the origin, if you like, of why independence is ingrained in your office as it is?

A. Yes.

Q. And indeed in your approach to it?

A. Yes.

Q. As far as practical measures are concerned with regard to independence, you've mentioned you don't answer to

the Scottish Government. You answer to the Scottish Parliament, as I understand it. How does that work practically in terms of, for example, where does the funding for your office come from?

A. From Scottish Parliament. So there's a corporate body. SPCB is the corporate body.

Q. Yes, the Scottish Parliament Corporate Body?

A. That's correct.

Q. Without getting into wishing to get into the bricks and mortar of the politics, but where does the Scottish Parliament Corporate Body get its money from?

A. I don't know, sorry, that's -- I presume Scottish Parliament and maybe assuming is means wrong, but Scottish Parliament have a different pot of money to Scottish Government.

Q. Yes, but ultimately, does the money not come from the people that's collected in taxes that goes to the government and is then allocated to the department?

A. Potentially. I'm sorry, I haven't investigated that.

Q. That's okay. You mentioned earlier you having an office. I think you tell us in your statement that it started off with just you and you've literally had to build it up really from the ground up, is that right?

A. Yes, yes.

Q. And you've now got a small staff --

A. Yes, I now have a team of four including myself.

Q. Yes, and we'll get on to other aspects of people who help new due course but it's quite unpredictable, I suppose for you at this stage, to be able to say what your office in your view might require to do because you haven't been able yet to understand, given that you've been setting up the office, the full scale of patient safety issues that exist in Scotland, is that right?

A. That's correct.

Q. So if hypothetically it were to be the case that you were to find that there were very extensive issues, many of which you felt you could assist with or try to uncover or recommend solutions for, how would you go about getting more funding to enable you to do that?

A. Yes, and also we don't even know if the Act is enough to give us the power. So there are lots of things that we're looking at even now.

Q. I understand.

A. So part of reporting to parliament, which we only do once a year in our annual report which I'm due to publish in the next few days but we also, once a year, go to the health and sports committee. So if we were looking for extra funding we would have to be -- it still has to go through the corporate body but we can also petition in the health and sports committee and

then obviously the health secretary as well.

Q. Right so the idea of that is that there's a public accountability aspect of that to the public --

A. Yes.

Q. -- rather than to the government and of course you're accounting to the parliament through your annual reporting mechanism. But also those would be fora in which you could raise issues about the level of your funding and the possibility that you might need to have more for the next year or something like that?

A. Yes.

Q. Understood. Just staying on the subject of independence, it is, I think as you have explained yourself, your intention to be independent is very important to everything you do but it's also important to be seen to be independent for patients, isn't it?

A. Yes.

Q. Why is that, do you think?

A. Because if patients have been harmed by -- you know, by a system then it's very important for me to not be part of that system. You know, I think fundamentally how we do significant event reviews and things like that you can understand the patients' concern if you were -- if you did an internal review, where is the independence in that?

Q. And it is I think a matter of trust and confidence in the outcome, isn't it, that the person doing it is doing it in a truly independent fashion?
A. Yes.
THE CHAIR: Not marking your own homework.
A. That was on the tip of my tongue to say but I'm trying to refrain. Yes, I think you're always going to get an A star if you mark your own homework. So I think that is something fundamentally that we need to look at in Scotland to make patient care safer.
MR DAWSON: Could we expand on that a little bit as to what aspects of the system do you think perhaps lack independence or lack being seen to be independent?
A. Well, you know, I think when harm has occurred it's not just about looking about what went wrong, it has to be around the system, proving that lessons have been learned and things are going to change. Whether that's one significant event that's happened or whether it's ten. Which is what I was talking about earlier on is that assurance gap. So I think we're improvement-rich because it's a paper exercise: this is what we're going to do, but that assurance of, has that actually happened, is where the gap is.
Q. And one aspect of the evidence that we've seen in this Inquiry is around systems like that requiring to provide

that assurance, not even just for the individual patient but so that others in future will not suffer the same outcome. That's a phenomenon we've seen in evidence from patients on a numerous occasions where those sorts of systems of investigation couldn't put anything right for them but they felt it was important that there be such assurance given that this would never happen to anyone else. Is that a phenomenon that you recognise in patient attitudes to these sorts of things?
A. That is almost every patient when they're making a complaint. Or two things: one, a recognition and an apology if you like and, two, they just don't want it to happen to somebody else. So a patient's intention in complaining is always almost 100%: look, I just don't want this to happen to somebody else, as well as a recognition like: look, we did a bad job and we got that wrong and this is what we're doing. And I think patients do need that assurance to say: because you spoke up, here's what we're going to do differently the next time.
Now, there's no guarantees in life that things won't happen again. I don't think we can ever assure people 100% but what we can do is do our best and implement change to make sure that that serious harm doesn't happen repeatedly.

Q. And I think, from what you've said, independence is an important part in providing the assurance to the extent that one can because it can't be a guarantee but to make it as robust as possible, independence is a key factor, is that right?
A. I think so.
Q. You mentioned there is another aspect that we have an interest in which is apologies. I don't know whether this is something that's come up directly in your role or something you have wider experience of but when apologies are made by healthcare providers, what are the sorts of characteristics that you think those apologies should have in order to be meaningful?
A. I think when a patient writes a complaint letter they have to have a reason for doing it. So -- and so that needs to be taken seriously. So whether it is just, "I had to wait ten hours and there was no bathroom for me", you know, whether it is a low-level complaint or whether it is actually that that true significant harm happened, it doesn't matter at the level of the complaint. The approach should be exactly the same, that the patient voice is heard, that it's not just -- it's not a "complaint" but it's actually them trying to contribute to the care that that institute is giving them.

So I think it's very important that that is recognised very early on to say: I really appreciate you taking time, you know, to write to me. Because what I worry about in Scotland, with a very diverse population, is at the minute, people that get through to my office are very articulate, can say what they mean, can write me an email and I worry about the patients who aren't so articulate. So that is why we're going out into communities and holding town halls to people who might not have an email. So how are we hearing from the whole population to make sure that everybody's voice is amplified when it comes to this? So I think with regards to complaints, I think at the early stage it's very important to take it seriously whatever level the complaint is at.
Q. There's a lot of very interesting material in there, Mrs Titchener, but if I could drag you back to my original question which was the important characteristics perhaps of the outcome of a process like that, which was apologies. If apologies are the ultimate outcome of a process like that, then what are the characteristics, do you think, that an apology should have to serve its purpose?
A. Well, an apology, for me, should be done in person. It shouldn't be done on a letter that's sent to you. But

it's more than that, it's understanding where the patient is coming from. And apologies hold no weight if they don't come with an action. So I can apologise to you for something that happened but actually if I'm not then saying to you, "And just to assure you that because you have had the courage to write to us, we have -- we are trying to change that process". So I think some of the stuff about this should be, you know, maybe listening to patients more and maybe having active patient groups and patient voices within boards so that we can make that change.

Q. Thank you.

A. I think we can't lose the voice of the patient.

Q. And on the subject of the complaints process, which you helped us with a moment ago, you mentioned that you consider it to be an important feature of a complaints process that the party raising the complaint or the issue is taken seriously. I took it and took -- that the reason for doing it should be understood, I took that to mean that the party making the complaint should be believed; is that correct?

A. Yes, 100%.

Q. Is that an important feature?

A. It's a very important feature. There has to be an acknowledgement and a recognition that -- and your

truth is your truth and you have to remember that. So if that is what I have perceived happened then that's why you need to listen to the patient. Every complaint that comes into our office we try and have an in-person or in-teams meeting because sometimes what's said on paper doesn't actually tell the true story. So we try and actually meet with people because we want to make sure we're understanding where they're coming from and we're hearing the heart of why they're feeling that something went wrong.

Q. There might be a multiplicity of reasons for that, I suppose, but one might be a matter you touched on earlier which is the systems, as you perceive them in Scotland as I understood your evidence, being perhaps better geared towards those who are more articulate and perhaps not to the full range of individuals who may wish to raise issues or complaints. Has that been your experience?

A. Yes.

Q. And that, I suppose, is a facet of the wider issue of health inequality?

A. Yes.

Q. Is health inequality more broadly something that, in your experience so far of the Scottish system, you've come across?

A. Yes.

Q. Could you give us some colour to that, some information about where that arises in a broad sense at least?

A. Yes, well, it is the inequity between rural and urban health provision and, you know, decisions being taken without looking at risk mitigation or without engaging with local populations. And, you know, part of what I have done, I'm actually trying to visit all the boards. I have got through seven and I did rural first because that was where the loudest voice was coming from and the loudest concerns were coming from, so we decided to visit the rural practices.

So I have driven the road from Inverness to Wick so I know, you know, if you're in labour what that road feels like, not that I was in labour, but you know, I wanted to walk the walk so that I could understand when patients were telling me things that I said: oh yeah, I know that road, that would be a tough road to go through. So that you know those are the kind of things that we're hearing.

Q. Thank you. I'd just like to return to a matter we touched on briefly earlier but you expand upon helpfully in your statement, which is the means by which you are able it comply with the statutory remit you've been given to look at things which are systemic, to translate

individual experience into systemic issue. And so you help us with that at paragraph 3.27 of your report.

If we could just scroll to that. I'm just going to read through a few paragraphs here. You say:

"These approaches are designed to support the identification of systemic issues and to promote learning and improvement across the healthcare system. The Act does not require me to wait for a pattern to be formally established before I can act. My functions include gathering and analysing information, publishing reports, and initiating formal investigations and I can exercise all of those on my own initiative. Individual patient experiences are not simply anecdote. They are data. When a patient tells me that their concerns were not listened to, that a risk was not communicated to them, or that something went wrong and no one explained why, that is a signal. When I hear the same signal repeatedly across different patients, different settings, different NHS boards it becomes a pattern. And patterns of that kind are exactly what my role exists to investigate and act upon."

Then at paragraph 3.30, you say:

"The threshold I apply is whether what I am hearing reflects a failure of systems, processes, governance, or culture rather than an isolated individual incident.

A single adverse event may be a tragedy. The same type of event recurring across different settings, or a review process that consistently fails to identify root causes or change practice, it is a systemic failure. That is where my remit begins.

"I would add one further point. The patients who contact me do not always frame their experience in systemic terms [when] they are describing what happened to them, and that is entirely right. Part of my role is to hold their individual account with care and respect, while also asking the wider question it raises. Those two things are not in tension. The individual experience is often the most powerful evidence that a system has failed, and it is my responsibility to make that connection visible."

So there's a lot of very interesting thinking there around how you deal with this dilemma, I think, of trying to take individual experience but to try to work out whether that is a signal that it triggers your systemic remit, I think?

A. Yes, that's correct.

Q. And how -- I think what you said earlier is I think in relation to, for example, an individual communicating to you there were no oxygen masks in a hospital or something. It is possible I think for a systemic

issue to be triggered by one individual, isn't it?

A. Yes, it is.

Q. It depends perhaps on the nature of the issue that is being raised?

A. Yes.

Q. So in some circumstances it might be that the systemic issue requires multiple individuals to tell you something is happening for it to become a systemic issue but in other circumstances it may be sufficient for an individual to raise that systemic issue with you?

A. Yes.

Q. And I suppose the skill in your job is working out when that threshold is met?

A. Yes, and that's something our framework is trying to do. And a little bit like I have articulated in this, you know every story is important because it adds to you know to the widening systemic. So even if it is -- I don't want to trivialise anybody's story, that's what I'm saying. So for me every story that comes my way is important.

Q. Do you think -- is it your understanding that the reason why a role was needed and required legislation to be passed and everything so that someone would do that apparently very important role, was that nobody was doing that within healthcare before, or there was

an insufficient amount of attention to that?

A. Yes, I think there is -- you know, there is good practice but I think there are certainly gaps. So yes, obviously clearly you know 20,000 people I think complained about mesh before something happened. So I think, you know, between the four nations, patients weren't being heard. It's not unique to Scotland but for Scotland certainly -- and Scotland have taken the position more seriously than anybody else. Northern Ireland and Wales actually have gone for a commissioner and England, the commissioner is only on medical devices and medicines. So, you know, I'm very grateful for the fact that Scotland has taken this role so seriously and actually said: no, we will give you independence and therefore the authority that that -- and the reassurance that that gives to patients.

Q. Because my understanding was that Lady Cumberlege identified that there was a need for this role to be created because there was a gap in the system?

A. Yes.

Q. The gap may not be that there weren't people trying to fulfil this function but that overall, this function of joining together individual experiences and to see that there's something systemic behind it was not happening sufficiently?

A. That's correct.

Q. There's an aspect of the evidence that you've given so far that I'd like to explore a bit further with you which is to do with the way in which people articulate that they have a problem with healthcare. You've identified, very helpfully, that that can vary greatly from individual to individual for innumerable reasons I'm sure, based on their own personal circumstances. One other aspect in this -- we're looking, in this Inquiry, at complaints systems and outcomes and we are interested in particular the extent to which patients are afforded ample opportunity to raise what one might call concerns or issues and the extent to which formal complaint systems may be difficult to engage with for various reasons. Some of the evidence that you've given has talked about the start of something being a complaint but if people feel unable or are unable to access a complaint system, no matter how formal or informal, that process never starts, does it?

A. No.

Q. And is it therefore important that when someone has an issue, a problem with their healthcare and that their opinion, as you've said, should be respected and should not be ignored and should become data, as you said in your statement, that the opportunity for someone to

express that they feel that way should be open to them?
A. Absolutely.
Q. And is it a phenomenon, either as a result of your researches over the last year what patients have told you or your wider experience, that complaints systems of whatever nature are difficult to access or, perhaps more importantly, that patients feel are difficult to access?
A. I think it's a number of things. I think there are time pressures on people who are looking at complaints, you know, because if patients are being told: we'll get back to you in nine months, one, that's not very reassuring. But two, it tells me that there's a pressure up the system, you know, if you have a backlog of complaints that you're waiting nine months to respond to. So I think there are many, many issues that are highlighted from that, and so I think -- sorry, can you -- I have gone off.
Q. I was interested in exploring the extent to which you consider it important that complaints systems, however formal or informal, be accessible to patients given the fact that they may, even if perhaps to a health board or to a GP practice they seem accessible, so there's a form there you can fill out, to a patient there is still the considerable hurdle in engaging with that?
A. Yes.

Q. Is that a phenomenon that you recognise?
A. Yes. Yes.
Q. Because in essence if you think about the concept of complaining, to take what we're interested in within a neurosurgical setting, all of the patients -- if not all, very nearly all of the patients are very seriously unwell when they're engaging with the healthcare system in neurosurgery; is that correct?
A. Yes.
Q. And they are engaging in a process -- we've heard some evidence about this already -- where they are very much giving themselves over physically, psychologically, emotionally to a system and placing their faith in that system?
A. Yes.
Q. And they trust that that system will handle them with care, is that a reasonable assumption?
A. Yes.
Q. And that when things do not go right it's often the case that they don't really know why that has happened?
A. Yes.
Q. And that that system in which they put their trust must seem like a daunting system to complain about. Do you think that's fair? Is that commensurate with your experience?

A. Yes, I think, you know, patients are inherently loyal to the NHS because, you know, they believe in it. But when a system has let them down I think they still will do it with reservation and disappointment because --
Q. There is a certain Britishness in that as well, I think. Reticence to complain about anything, perhaps the NHS most of all, is a phenomenon that people tend to recognise?
A. Yes.
Q. Would you say, therefore, from your patient-centred, patient safety perspective, that it's important that there are multiple systems in place to try to detect when things are going wrong that don't rely solely on patients speaking up and in many ways that's part of your role?
A. Yes.
Q. Because part of your role, from the passage that I have just read out, involves very much collecting all of the data from patients and putting it together to try to work out whether there's something systemic going on?
A. Yes.
Q. And what you are doing in that exercise one might use the word is "triangulating" the data?
A. Yes.
Q. To try to see the bigger picture?

A. Yes.
Q. And it's essential that you do that?
A. Yes.
Q. Because otherwise it might just seem to the individual that this is just a problem that's affected me?
A. Yes.
MR DAWSON: Thank you. Sir, that would be an appropriate moment for a break if it would be convenient.
THE CHAIR: Thank you. Mrs Titchener, we're going to have a short break for approximately 15 minutes. Ms Miller will take you back to the witness room. I'm just going to mention something I always mention to any witness in your situation, please don't discuss your evidence during the break. We will see you again in a quarter of an hour's time.
(11.10 am)
(A short break)
(11.26 am)
THE CHAIR: Thank you, Mrs Titchener, we're ready to resume. Mr Dawson, when you're ready.
MR DAWSON: Thank you. Can I just ask you some questions, Mrs Titchener, obviously your title includes the concept "patient safety" and you've helpfully provided in your statement some comments on how you might go about interpreting that. So if we go to the statement,

please, at paragraph 3.5.
3.4 you say:
"On the specific question of care, experience and satisfaction, I would draw a practical distinction."
And you set out your definitions, if you like, of these different things. You say:
"Patient care being the clinical and organisational quality of what is delivered which falls within my remit where it carries safety implications. A system that routinely fails to assess a patient's risk before a clinical decision is made is a patient safety issue, not simply a care quality concern."
Then you say:
"Patient experience [at paragraph 3.6] is directly relevant to my remit where it signals underlying safety risk. When patients consistently report not being listened to, not being informed of risks, or [then, over the page] feeling unable to raise concerns, that is not merely a satisfaction issue it is evidence of a system that may not be safe. The Act explicitly requires me to promote the importance of the patient voice in relation to safety, which means experience is a legitimate and important source of evidence for my work.
"Patient satisfaction in the narrower sense, for example, whether someone found a ward comfortable or

a clinician approachable sits outside my primary focus. My statutory purpose is systemic safety improvement."
So, you've obviously had a think about these different things and what "patient safety" in the title means. It seems from that, as far as I could interpret it, that you've taken probably quite a wide definition of "patient safety" including a number of aspects which might not technically be deemed to fall within it but which ultimately affect patient safety; would that be a correct interpretation?
A. That's correct.
Q. Because again, oddly, we have toyed and struggled with aspects of our Terms of Reference where they talk about patient safety, as they do in places and "patient care" for example and they also talk about "treatment" and we've certainly taken the view that we're not looking just at treatment, in the sense of surgery or whatever, but looking at a broader patient experience of that. So it's not just the surgery itself but it's the experience of the care that was received by the patient.
Is that broadly comparable with the sort of approach that you've taken and anything that can impact on patient safety you're prepared to look at?
A. Yes, it's that lived experience that only they have to do with their care.

Q. Okay. And I think you say in the statement that "patient safety" is not defined in the Act?
A. No.
Q. One might find that odd but I think you say that your interpretation at least that was deliberate to allow to do it; is that right?
A. Yes, exactly.
Q. And obviously this is part of your thinking as to how you've done that?
A. Yes.
Q. Could I ask you some questions about your powers. You are able to undertake formal investigations?
A. Yes.
Q. Is that correct?
A. Yes.
Q. I think that falls -- if we go back to the Act, please, although I'm quite keen, as I said, to avoid it if we can. It's ELJ-00559. Looking at page 4 at the bottom, section 8 deals with the initiation of formal investigations. It sets out a process whereby there are various steps that need to be taken including you coming up with Terms of Reference and then, over the page, there are various requirements to make them publicly available, information to be supplied and then, under section 9, there's a definition of what the Terms of

Reference need to look like. Section 10 has provisions relating to an investigation report.
Are you able to investigate things other than by way of a formal investigation?
A. So we would call that an informal, yes. So that's the approach that I have been taking so far where -- that if somebody is putting something forward to me that I feel is a safety issue, I will approach the boards on that and ask the -- you know, say: I have heard this from the patient with the patient's permission.
Q. The reason I ask that, Mrs Titchener, is it occurred to us that those provisions are potentially quite cumbersome in terms of the number of procedural steps that need to be taken for a formal investigation to happen?
A. Yes.
Q. Which might not be appropriate, for example, if dealing with what you described earlier is a "now" issue?
A. Yes, I agree and that's where we're taking legal counsel and we've only just got that in place to say: if we're not taking a formal process, what are we able to do prior to that? So at the minute with all the health boards we are doing, an understanding to say: if I am concerned about something what do you want my process to be? And, you know, that's around me speaking to the

Chair and then what does that look like? So that -- because in the early days, they were like: who is this and what's she asking and why's she writing? And maybe five emails in, I was getting the answer that I was looking for. So I think you have to remember we're a very new office and so people are trying to work out, well, who is she and what powers does she have and why is she asking this question.

Q. We heard some evidence yesterday about an issue that exists in the health service about people not reading emails, so at least they read them I suppose?

A. Yes. Well, I do say they have to respond within 24 hours, so hopefully they do.

Q. I see, you have some other powers, if we scroll on further, that -- under paragraph 12 you can require information as part of a formal investigation, I think?

A. Yes.

Q. And under -- that can be from, I think, healthcare providers including health boards?

A. Yes.

Q. And under paragraph 14(4) there is an ultimate sanction, I think, that you can make an application to the Court of Session for an enforcement order which can treat the failure to comply with your request for information as a contempt of court?

A. Yes.

Q. I take if from the broad description you've given of what you've been doing so far that you haven't launched any formal investigations yet?

A. No, almost a couple of times but again, because we're waiting to make sure that what we are -- the process that we're doing matches what the Act says, we haven't triggered that.

Q. But there have been a number of informal things that you've done, I think?

A. There have been multiple informal things.

Q. Yes, thank you. Sorry to jump around a bit, but could we go back to the statement at paragraph 4.12. You say there:

" ... the principal distinction is that the Patient Safety Commissioner for Scotland is not a provider, employer, inspector, educator, professional regulator or government department. The Commissioner's role is to bring an independent, patient-centred focus to patient safety across the system, to identify themes and risks, and to promote improvement. Any overlap with the bodies listed above [which are health boards, etc] is therefore limited and complementary, rather than constituting duplication of their statutory or operational responsibilities."

One of the core functions that you have is to promote improvement, I think?

A. Yes.

Q. But you say there that you don't consider your role to be an inspector. I just wanted to tease out from you what it was that you meant -- where the boundary lay there?

A. Well, that's Healthcare Improvement Scotland role. So therefore the terminology that the Act has used is "investigation". So that doesn't mean that part of that investigation doesn't go and walk the corridors and, in no uncertain terms, does inspect. But the role is that would be to inform the investigation as opposed to a formal inspection.

Q. Do you have, or do you intend to have -- I think you mentioned a moment ago memoranda of understanding, common phenomenon is Scottish public services, that you were intending on having that to clarify your role and access rights and all that sort of thing with health boards. Do you have, or do you intend to have, that with other bodies, for example Healthcare Improvement Scotland?

A. Yes, so Healthcare Improvement Scotland we're just about to sign off on our memorandum of understanding and also with the Ombudsman because again, both of those bodies

will be able to see key things themes and things that they're concerned about.

Q. So is that an attempt -- it probably does a number of things. Does it clarify the roles of each body?

A. It does.

Q. And does it attempt to, perhaps the word I used earlier was "triangulate" your various different data sources, if you like, to try to promote healthcare improvement in patient safety?

A. I agree. It's in a spirit of collaboration to say: we all need to be talking together because no individual organisation can do this on their own. We're all in this together to make care in Scotland safer, therefore how do we work together without walking on each other's toes.

Q. And does that collaboration extend, in a practical sense, to you being able to be involved in the inspections that Healthcare Improvement Scotland would undertake?

A. No.

Q. No, but it would involve what sort of steps to try to promote that collaboration?

A. So, the sharing of information, you know, if we are concerned about something that we could raise that with them and say: are you concerned? You know, have you had

any contact with this? So we're just trying to, a bit like you said, triangulate that information.

Q. I see. I see, so for example hypothetically, you obviously would have a more patient-facing role, patients would be telling you things, and then you wouldn't be able to do an inspection but it could be that that information might be helpful to an inspection being contemplated by Healthcare Improvement Scotland?

A. Exactly.

Q. And what -- in fact, this organisation has changed. There was an organisation called NHS Education for Scotland which has become part of a different organisation called Public Services Delivery Scotland. I happen to be an expert on that because I have a witness from that organisation this afternoon. However, they are involved in training of resident doctors and other health professionals. Is that a body into whose operations you would wish to have some information sharing or is it a body with whom you plan to have a memorandum of understanding?

A. Not at the minute, we haven't considered that.

Q. Because again, through the evidence we've heard in this Inquiry and our remit, one of the things that we're keen to look at in our -- as you are aware, our ambition to try to find answers to things and to promote patient safety, is

that we are looking at the way in which doctors are trained.

A. Yes.

Q. And it may well be that there are various organisations that contribute to that complicated exercise but some representation of patient concerns and patient voice in that process, I think would you agree, would be a useful contribution?

A. Yes. Yes, I have had a discussion with the GMC around doctor training, around speaking up actually to say, you know, just because you're a new doctor and you have your surgeon, are you coaching them into how you could speak up because I think it needs to be part of the training. So I have brought that up at a recent education meeting with the GMC. So I feel that's a very important thing around doctors' training.

Q. Was that an area in which you felt there was weakness or was it just an observation you felt there was --

A. Well, it was because of this current -- you know, Mr Eljamel, that I was wanting to say: well, how do we, with doctors' training, how do we ensure that junior doctors feel able to speak up even if the person that they're speaking up about is somebody that's a much higher pay grade than they are?

Q. Excellent. Thank you very much. I'm not going to go

through the complicated provisions of the Act which have prescribed, and continue to prescribe on you, that you require to take various steps effectively for your office to be able to carry out its important functions but as I understand it, the Act requires you -- this is an ongoing obligation because I think although you've done many of these things, there's a need to continue refreshing documentation and things, but I think you need to set up, as I understand it a set, of principles, a charter and a strategic plan; is that correct?

A. Yes, that's -- you have those.

Q. Yes. So all three of those have now been done?

A. Yes.

Q. And could we have a look, please, at PSC-00005. And these are the principles that I think you've published in accordance with your statutory obligation. How were these compiled?

A. So these were my first thought and then they went before the advisory group which, by statutory law, has to have the 50% patient representative and 50% professional and then it had to go through the corporate body before it could be agreed.

Q. Just on the subject of the advisory group which was something I was going to touch on. As you say there is a statutory requirement for it to have a certain make-up

and that is a body which is there to help you discharge your functions and is, I think, one of the mechanisms by which, for example, the patient voice is heard by you as well as many, many others but is a more formal role which includes patient representation. How did you go about finding people that would be part of that group and what were the characteristics that were thought to be useful?

A. So that was -- again, I was new to Scotland so I literally didn't know anybody. So that was around me getting out, meeting people, speaking to patients and I think -- and then deciding who would be helpful because of their -- so if it was somebody professional, it was because of the experience that they had had and what they could bring to the table and add beyond my experience. And then for the patients I wanted to make sure there was a good mix of different stories, and that they were not just going to be advocating for their own corner but that they literally wanted to represent, you know, patients from Scotland.

Q. I see and so the patient representatives, are they people that are sort of found by you or is there an application process?

A. No, there is not an application process. We would write to people and say -- and actually we're just about to

add a few more people. We started with six because that was the limit of my knowledge at that time and we're growing that to, I think, about ten.

Q. And if I could have a look then back at the principles document we were looking at. You have set this out in the form of looking at -- the various principles that are included in it are first of all, that you will "listen, include and act on patient voice". Second, "make safety a shared, system-wide responsibility", third, "focus on systemic learning and improvement", fourth, "champion openness, transparency and accountability". Then over the page, "5, use evidence, data and insight to drive change", "6, act with independence, integrity and public interest".

Now, one of the things that you set out in this in the principles is not only what the principles are, but you have set out why you've included them. Why did you think it important to say why?

A. Well, because otherwise they're just random -- I thought it was important -- remember I'm a public-facing office and I'm here to serve patients. So I wanted to make sure that patients had understood why I chose those principles.

Q. Yes, and it's important for public authorities and public-facing bodies to explain why they do things?

A. Yes.

Q. Thank you. And you've also -- you also have a charter which is PSC-00006 if we could have a quick look at that, please. My understanding was that this set out, in accordance with the statute, slightly different things. One is it explains what patients and families can expect when safety concerns arise?

A. Yes.

Q. And also separately what you expected from healthcare providers and product public bodies with regard to public safety. So the first part is seen there and if we scroll on further, I think the last part is on the last page, could we go to that, page 4. Thank you. There you set out the expectations of the healthcare providers and public bodies:

"Providers and public bodies are expected to.

"listen and respond to patient and family safety concerns.

"Be open and transparent about incidents and learning.

"Act promptly to reduce risks and prevent recurrence.

"Cooperate with the Commissioner and provide relevant information.

"Foster a culture where staff and patients feel safe to speak up.

"Communicate inclusively and accessibly."

And then, under the further bullet points:

"The charter will be publicly available.

"A safety management system will be used to log and manage concerns.

"Progress will be reported through annual reporting.

"[And] the Charter will be reviewed regularly in consultation with stakeholders."

That last section is titled "Accountability" because it's important public facing individuals are accountable for their actions, isn't it?

A. Yes.

Q. As far as the expectations of the bodies are concerned, how -- it's a succinct list, but how was that compiled?

A. Again, it was just my process of listening to patients and making sure, from what I had heard, that we -- you know, it feels very sad that you have to articulate this but this was what I really felt I needed to be saying to people: this is how you should be treating patients.

Q. You're one step ahead, Mrs Titchener, because that was precisely the point I wanted to raise with you which was although this is a very helpful, succinct list, it's not exactly reinventing the wheel. One might have thought that these are principles that healthcare providers would have at the forefront of their operations as they are really the cornerstones of really having any regard to patient safety, one might say?

A. Yes. Yes.

Q. So these are not innovations?

A. No.

Q. These are simply, perhaps in your office given where you are, really just a starting point?

A. Yes.

Q. Which you would expect everyone to be doing anyway?

A. Yes, and we're taking it one step further, in fact, because we were asked by a patient if we could put together a framework for which boards would interact with patients. So we've now got a working party, all of patients and it will be their words, we're just helping them to actually put together a framework for us to give to boards to say: when you're interacting with patients, here's how we want to be treated.

Q. Okay, thank you. We talked earlier about the possibility that systems that may exist for raising concerns or complaints may be difficult to access or penetrate and it may be that those with legitimate issues or concerns might feel reluctant to do so. The same might potentially be the case with your office in that people might not know you're there or how to access

you or feel reluctant to step forward. What steps do you take actively to seek out patient experience so as to inform your work?

A. Yes. So we now have our website up and running so patients can access that and have been accessing that to get through to the enquiry line. Obviously, we're -- we've got our Facebook page now, we've got a LinkedIn page, but more than that, I'm trying to make sure -- and I'm doing a reasonable job but trying to do better -- at making sure I'm activating all patient voices and patient groups within society. And earlier on I talked to you about doing town halls, so going out into the rural areas. And rather than doing it in a public forum people might still feel nervous to speak out, we have given time-slots to say where you have a half an hour with the commissioner or somebody in her team. Because again, that's trying to address, you know, people who may not be as articulate and not want to talk in a public forum. So we're trying to do things like that.

We've reached out to patient advocacy groups, you know, we've reached out to the homeless society. We also have somebody from the Royal Institute for the Blind because we're making sure our website is accessible for them, they actually sit on our advisory group. So we're doing our best to try and reach the

mixed population that Scotland is.

Q. Thank you.

THE CHAIR: Sorry, Mr Dawson, just to pick up on one point and I think I know the answer but I'll ask it anyway. In terms of the patient contribution to putting together these constitutional documents that you talked about from these six, possibly moving on to ten, and referencing the specific example that you did just now about a patient who had advocated for a framework for you to connect with health boards, may I take it that the insights that have been shared with you by reaching out to patients in this way has been of benefit to you in helping to put together this framework?

A. Extraordinarily so. The patients are amazing people and they have great insight into what's going on, so I think I have a great job being able to interact with them and help them move things forward.

THE CHAIR: So there might be some lessons to be learned from that as well?

A. Absolutely.

THE CHAIR: Thank you.

MR DAWSON: Is the phrase "trauma-informed" something you're familiar with?

A. Yes.

Q. Does it feature in your approach to your work or will it

do?

A. Yes.

Q. One hears often about various agencies stating that the way they go about things is "trauma-informed", what do you understand that to mean?

A. Well, it should really mean that their interactions should be done in a sensitive way that doesn't bring back all the trauma that happened previously. So it should be aware of how to articulate and how to interact with that person that doesn't diminish what went on before but also doesn't reinforce it and start it all happening again.

Q. I see, so it's a sort of prerequisite to a trauma-informed approach that there should be, in the person that one is interacting with, some previous event that has caused that trauma?

A. Yes.

Q. What one is seeking to do is to try not to, I think you said to cause a recurrence -- but to recognise that that trauma will have an effect on that person?

A. Yes.

Q. I wonder if you, either through your work so far or your more general experience and knowledge of patients, have experience of issues that patients experience within the healthcare setting of document management? Do you have

issues -- do you have experience of patients having issues with those sorts of things?

A. Yes.

Q. Access to notes and that sort of thing?

A. Yes.

Q. Please say if I'm going beyond the remit but I'm interested to explore with you, given your experience, how important a part it is of a patient's experience of healthcare that it is properly documented and that there are clear records that they can then access themselves about what has happened to them?

A. I think it is very important and I think we have to look at a system where, on my phone app, I can see exactly what the doctor wrote in my notes and reassure that that's -- that that's accurate. Because a lot of our interactions when they've asked for, you know, freedom of information and they've got their notes through, they're just like: well, hang on, that doesn't match the conversation that we had or they haven't mentioned this. So I think -- and I have been a nurse a long, long time and, you know, if you haven't written it, you didn't do it. And maybe that's not what they say these days but I would still say that. So I think documentation for patients particularly as well as for patient safety, is very important.

Q. Yes, nurses saying if they haven't written it they didn't do it can come back to bite them sometimes in my experience but the point that you made about it being on a phone app is perhaps interesting because is there a distinction to be made between that solution -- I'm sure there are all sorts of technological issues with it but that idea and the alternative which you have proposed, which is somebody going through a lengthy process to be able to access their records finding, as you hypothesise, as some patients say they have, that what is written does not reflect the reality of what happened.

But the problem with that is that it's not instantaneous. So there is a process to be gone through, it may be many years before the patient asked to see the notes, they may not be complete. Does the phone app concept incorporate within it something more of an instantaneous ability to access notes, to try to address some of those problems?

A. I definitely think that that's how we have to move. I think technology is moving at speed and health technology does not move at speed and if you see a doctor in one city, your notes don't transfer to the next appointment. So that in itself is a risk.

Q. Yes, and in terms of moving then out of healthcare

generally, more into what your own practice is going to be, and it may have been formerly, one of the issues which does exist, no doubt for you as well as in healthcare relating to recording information, is the importance of confidentiality. It is important, as you've recognised and you have committed to, you will gather patient experience, hear the patient voice and seek to advocate on behalf of the patients, but how do you intend to gather and retain data, as you've called it, information from patients? What are your thoughts, what are your systems going to be for that?

A. Yes. We're just about to start a case management system which is -- you know, it's a confidential data base that we will put all the patient interactions in. So that's how we're going to be dealing with that information.

Q. And will patients -- sorry, will patients approach you not in that capacity but approaching you as somebody who wants to raise an issue, will they be aware of what your intentions are with regard to what will be retained of what's discussed, if I can put it that way?

A. Yes.

Q. I wonder whether, in your investigations so far and in your setting up of your office, you have any sort of feel at this stage as to the level of the healthcare system which you feel you may need to interrogate or

investigate or look into in order to try to promote patient safety. So for example would it be at the lowest level or at the hospital level or at the government policy level and do you feel that all levels of the healthcare system would be open to you to try to interact with and influence?

A. So what are you asking me about the interaction?

Q. I'm focusing more or less on what the interaction will be and more on what level of the system you feel you would be empowered or intend to interact with. Because obviously healthcare is provided from the very first time you walk through the door all the way up to the government effectively. So all of those things one might say require the patient voice to be heard in order that patient safety is prioritised. But where would you feel -- at the moment -- it may be too early to say -- if you can say, that your influence would be best expressed or your investigations might be best addressed?

A. Well, at the minute the process is that in the first instance we talk to the chief executives of the boards for every, you know, question or query that we have and that is that process.

Q. Okay, thank you. So I'd just like to ask you a couple of questions about how the role fits in with some other

systems in the UK because obviously the Cumberlege Review gave rise to patient safety commissioner, for example, for England being put in place. I think you say in your statement although it's not an obligation for you to have interaction with the patient safety commissioner in England, you have decided to do so?

A. Yes.

Q. I think you say you maybe sit on advisory board for that role?

A. Yes, I do.

Q. And is that a part-time role, the English role?

A. No, it's a full-time --

Q. It's full-time role, right. So it really is pretty much the equivalent of the role that you hold, but just a different jurisdiction?

A. It's a different jurisdiction, yes.

Q. And it's not restricted in any way, as I asked you earlier, as to whether it's restricted just to do with medicines and medical devices?

A. It is, it is only. And it actually not sits with MHRA, so not a truly independent role.

THE CHAIR: Just so everybody understands, what's MHRA?

A. I knew you were going to ask me that. It's the medical -- it's the regulatory body for medicines and medical devices.

THE CHAIR: Thank you.
MR DAWSON: So the role is more limited in the scope, it deals with just the things that were concerns in the Cumberlege Review?
A. Yes.
Q. Whereas your role is far more wide-reaching?
A. Yes, but the population is 70 million.
Q. Absolutely. One might say that one could have a bigger office to deal with more things but that is a difference. The other difference is that there isn't this ingrained independence --
A. Yes.
Q. -- that you have. You report to the parliament, as you said --
A. Yes.
Q. -- but that now sits within -- effectively MHRA would be a government agency or something like that?
A. Yes.
Q. Thank you. We asked you -- although you've helpfully provided some answer although it necessarily logically pre-dates your taking the role, we asked you some questions about why it had appeared to have taken so long for your role to be filled and you have given us what helpful answers you can about that. The Cumberlege report came out in 2020, is that right?

A. Yes.
Q. And I think the English role was filled in 2022; is that correct?
A. Yes, that's correct.
Q. And there seemed to be some significant difficulty in filling your role, is that right?
A. Well, I know that I was recruited on the third round, so -- but as I wasn't in Scotland so I don't know what that difficulty was.
Q. Yes, I understand the limitations but does it -- do you know, for example, whether in the first instance they were just looking within Scotland and then they went more broadly and that's why you became a potential candidate, is that what they did?
A. I honestly don't know, I'm sorry.
Q. Right, it does seem perhaps, on one view, quite odd that there wouldn't be a number of people within Scotland who would be keen to put themselves forward for the role and that there would be, one would imagine, a number of people with a qualification for it, would you agree?
A. Yes.
Q. Would it be reasonable do you think, based on the fact that it took so long to fill it and your experiences, some of which you've helpfully relayed to us to date, that that might tend to indicate there isn't a great

interest in patient safety in Scotland?
A. I don't think that's the case. I think probably people who know Scotland know that perhaps it would be -- it could be a bigger role than they might want to do.
Q. Yes. I understand, yes. You've had some interaction with some of the patients within the Eljamel group, as I think we've touched on?
A. Yes.
Q. And in your statement I think you candidly tell us that there was -- you had a degree of reticence and reluctance in discussing matters with them while there was an ongoing public inquiry?
A. That's correct.
Q. One of the aspects of that that you might not be aware of is that this Public Inquiry is looking predominantly at healthcare systems within the NHS, rather than looking at systems within private care, although Mr Eljamel did have a private practice and there are large numbers of private patients who also have suffered adverse outcomes and claim -- or suspect things have gone wrong within those systems.
Given that that is not within the remit, would that be something that you would feel more comfortable about interacting with them to do with? The reason I ask is I know -- I didn't set the Terms of Reference for this

Inquiry but I know there are private patients who are, understandably I think, upset about the fact that this Inquiry won't cover the full ambit of the care that Mr Eljamel provided and I think they might be interested in trying to find other avenues for exploration, not of course in a historic sense, but in the sense of trying to have an outlet for what they've learned and their patient safety concerns. Is that something, given that I have clarified the remit, that you would feel more comfortable in becoming involved with?
A. It is something that I could consider. But again, given the remit of the historical -- within the Act it's -- and obviously it's a longer time than -- you know, I know you're also doing it and it was ten years ago or whatever. So I think it's something that -- it isn't something that I have thought about, so thank you for bringing it to my attention. So it will be something that we can definitely look at.
Q. Absolutely, thank you for that. Just again, to go back to -- we discussed this point before but in terms of the historic, you focus very much, when we looked at that section of the Act, I think on the fact that you don't have any powers and your role is not about giving redress for past grievances but that doesn't prevent you looking at past events. In fact, you told us everything

is a past event you look at in order to help healthcare in the future; is that correct?
A. Yes.
Q. And I suppose the point you're making about how long ago things may have happened is to do with the extent to which something more historic is, logically, less likely to have an impact on where we are now in the healthcare system?
A. Yes.
Q. Although it's not impossible at all?
A. Not impossible.
Q. And one can often learn lessons from the distant past that can resonate in the present --
A. Yes.
Q. -- do you agree?
A. Yes.
Q. Thank you. Excuse me just one second. Could I just go to the conclusions please in your statement, paragraph 15.4. You help us out with some conclusions based on your work so far. You say there from this work, which you say above is based on your general experience and engagement with patients, families and stakeholders, you tell us that you:
"... have observed that the promotion of patient safety is closely linked to:

"The extent to which patient voices are heard and acted upon.
"The effectiveness of systems raising and responding to concerns; and.
"The transparency of communication between healthcare providers and patients."
So, systems to allow patients to raise concerns need to be effective to promote patient safety?
A. That's correct.
Q. And they need to take action to -- they need to take action to promote patient safety?
A. Yes.
Q. And to be able to understand and explain what action they are taking and why?
A. Exactly.
Q. As you've explained why in some of your documents. If these things are not done, patient safety will generally be undermined?
A. Absolutely.
Q. And if there is a lack of transparency with patients, that undermines patient safety too?
A. It does.
Q. And transparency with patients is not just a matter for doctors but it's a matter for all healthcare providers, isn't it?

A. Yes.
Q. And you go on to say, at paragraph 15.5:
"I have also observed that patients and families may experience difficulty in navigating systems when concerns arise, particularly where those concerns relate to serious harm."
Systems which are not accessible undermine patient safety?
A. Yes.
Q. And you say, at 15.6:
"These reflections are general in nature and not specific to any individual clinician, organisation or specialty.
"In my time in post, I have reflected on the importance of ensuring that systems are sufficiently robust to identify and respond to patient safety concerns at an early stage."
You say:
"Ongoing attention to transparency, patient involvement and system learning is, in my view, essential in supporting confidential that such issues are unlikely recur.
"In my role, I have reflected on the importance of ensuring that systems for identifying and responding to patient safety concerns are sufficiently robust and

effective.
"In particular, I consider it essential that patient voices are heard, that concerns are acted upon at an early stage, and that learning is identified and applied consistently across the system.
"Continued attention to these areas is important in supporting confidence in the safety and effectiveness of healthcare services."
So in healthcare, patient voices must be heard?
A. Yes.
Q. And if they are not, that can undermine patient safety?
A. Yes.
Q. And learning needs to be identified and applied consistently?
A. Yes.
Q. And if it is not, that can undermine patient safety?
A. Absolutely.
Q. And you also mention there the importance of patient confidence in systems designed to promote patient safety. Why is it important that patients are confident in the systems that provide their healthcare?
A. Because if they're not confident then, you know, they're not going to go, for a start. And that has happened with some of the stories that I have been involved in, they don't want to talk to a healthcare professional

because it went so wrong. So I think there has to be that confidence. But also that confidence that when they do speak up, that actually they're going to be listened to it will be acted upon. That, for me, is equally as important.

Q. So there are a number of aspects of that I'd just like to clarify. In circumstances where a person has an initial treatment that goes wrong and that experience involves poor communication, then if they are in a position where they need to go back and seek further help because of what went wrong, they're less likely to do so because of that initial experience; is that correct?

A. Absolutely, that's correct.

Q. And that's because, I think, that their trust in the system has been eroded?

A. Yes.

Q. And trust in the system is important as a general concept but for some patients who have suffered physical or psychological harm it's essential to their future well-being?

A. Yes.

Q. Thank you. Mrs Titchener, those are the all the questions I have for you.

A. Okay.

Q. Thank you very much. At this stage we'll have a short break and offer an opportunity to our core participants to propose some further questions for you.

A. Okay.

Q. But as I do with all witnesses at this stage, I'd just like to invite you: is there anything further you'd like to add?

A. No.

Q. Thank you.

A. Thank you.

MR DAWSON: So sir, a short break.

THE CHAIR: Yes, thank you Mrs Titchener.

Ms Miller will take you back to the witness room for a short break while we deal with the next stage in our procedure and we'll resume again as soon as. Thank you.

(12.11 pm)

(A short break)

(12.20 pm)

THE CHAIR: Thank you. Can we have the witness, please.

MR DAWSON: Sir, just one question, Mrs Titchener, possible follow-ups. It's a question relating to the interaction you had with the Eljamel groups, patient groups. As I said earlier, there has been a consistent body of evidence presented to us, which I think you recognised, of people wishing that information be ingathered for the

purposes of prevention of things happening to people in the future and the improvement of systems. The patient group was keen to know whether you had formally recorded the information that they had given to you in order that it might serve that purpose?

A. No, not at the minute.

Q. Does that mean you still have the information that they've communicated in whatever form that was, or --

A. So I still have the emails.

Q. Yes, so you have the information but it's not been formally recorded in a way yet?

A. No, no.

Q. So it's still available for you for that purpose?

A. Yes.

Q. Thank you. There's nothing further, thank you very much.

A. Thank you very much.

THE CHAIR: Thank you very much. Mrs Titchener, that, as you will have gathered, is the end of your evidence. Can I, before you leave the witness stand, thank you very much for preparing for giving evidence today and the statement that you provided, the associated materials, but also for sharing your reflections and insights today. We found it all very helpful and all very interesting. With that and my thanks, you're

free to go.

A. Thank you. Thank you very much.

MR DAWSON: Sir, there are various matters that need to be attended to over the lunch break so I'd ask for a slightly longer lunch than we normally have, maybe 2 o'clock?

THE CHAIR: 2 o'clock, yes, that's fine. Thank you everybody. We'll resume again at 2 o'clock.

(12.22 pm)

(The short adjournment)

(2.09 pm)

THE CHAIR: Thank you, good afternoon.

MR DAWSON: Sir, the next witness is Emma Watson.

THE CHAIR: Thank you.

PROFESSOR EMMA WATSON (sworn)

Questions by COUNSEL TO THE INQUIRY

MR DAWSON: Thank you, sir.

Good afternoon. You are Emma Watson?

A. I am.

Q. It's Professor Watson, is it?

A. Professor Watson.

Q. You provided a witness statement then on behalf of NHS Education for Scotland to the Inquiry, I think; is that correct?

A. Yes, I did.

Q. Can I just say before I progress as I say to all the witnesses if you can try to speak into those microphones. It's quite tricky because they come from both sides but just to make sure everybody can hear you that would be brilliant. Thank you very much indeed.

Can I have up, please, on the screen, NES-00083. This statement, on the front, bears to be dated 17 March 2026 but is that your statement?

A. Yes, it is.

Q. Can we go to page 32, please. Scroll down a little and the statement has been signed by you, yes?

A. Yes.

Q. And the signature was actually dated 18 March, yes?

A. Yes.

Q. And as far as you're concerned are the contents of this statement true?

A. Yes.

Q. Thank you. You are a medical doctor, I think?

A. Yes, I am.

Q. And the statement which you've given at page 1 tells us that your qualifications are MBChB with an MSc in public health and health services research and you also tell us you're a fellow of both the Royal College of Pathologists and the Royal College of Physicians under medical microbiology.

A. Yes.

Q. Is that all correct?

A. Yes.

Q. There's a few things I'd like to ask you about in that regard which are of general interest to the Inquiry. Did you practice as a doctor before taking up your current role?

A. Yes.

Q. And what field?

A. In medical microbiology.

Q. Right, and when did you graduate with your MBChB?

A. 1992.

Q. And is that an undergraduate medical qualification?

A. Yes.

Q. And I'm using you as something of an illustration to point out some aspects of medical education but one of the expressions that we will hear in your evidence I'm sure as it features in your statement is a "resident doctor in training"?

A. Yes.

Q. Could you tell us what that is please?

A. So a resident doctor in training is a doctor from post-graduation until they achieve their certificate of completion of training or until they step out of a training role and take up a role as an employed doctor. So examples would be the foundation programme which are the first two years post-qualification that resident doctors in training undertake now. Halfway through that point they get full registration with the General Medical Council. Up until that point they're provisionally registered.

Following the completion of foundation training, doctors have various choice points they can make, they can step away from training but we encourage them to work in supported environments because they're very early on in their career. Or they can choose to go into a training programme. Those training programmes are appointed competitively through a national process across the whole of the UK. There are some programmes that we recruit to solely in Scotland.

Q. Okay.

A. And then --

Q. Could I just stop you there because I just want to take that step by step. This material will be extremely familiar to you but just so that we understand the various different stages. So effectively one finishes a medical degree and usually into the degree MBChB which you've explained already and then after that I think what you've told us is there would be a period that one goes into of further training and that there could be a number of different paths that could be taken by different people; is that correct?

A. Yeah.

Q. Is it the case that for all doctors one goes through this foundation year -- two years, I think you said?

A. So all graduates from the UK must undertake foundation programme to achieve GMC registration.

Q. Right, so when you graduate from university you're not a registered doctor but after two years you can become one?

A. At the end of the first year of foundation the majority become fully registered with the GMC.

Q. Right, and when you talk about "foundation", what is it that someone is doing over that period, what are the ranges of activities one can be doing?

A. So they're consolidating the clinical learning they've had in their undergraduate degree and they are becoming used to the acute care environment and we would expect that the doctor at the end of foundation to be able to manage the acutely unwell patient within a supported team environment.

Q. And then at the end of that, I think you mentioned the possibility that one would enter training, is that right?

A. So at the end of F2.

Q. F2.
A. So probably from about now I think specialty in core training applications open in November. The current foundation 2 doctors will be starting to think about what is the next step for them in their training pathway.
Q. And so this training period, is that where one becomes a resident doctor in training?
A. So they're a resident doctor in training from the time they take up their F1 post until the time they leave training and they can leave training at various points and we give various certificates of completion. So at the end of foundation, the two-year training period, you get a certificate of completion of foundation training. That means that you are competent to work to a certain level. Generally, it would be expected that a doctor post-foundation training would still be working in an environment that was supported. They wouldn't have the evidence to be competent to practice independently and operate at the level of, say, a specialist or a consultant doctor.
Q. Right. So when one enters the training process, that would be after the FY2 year; is that correct or ...?
A. So if you were going to enter core or specialty training that would be after F2 but we consider the whole

programme training from foundation forward.
Q. I see, so what comes after the FY2 year?
A. It depends on the pathway that the doctor chooses to take. So in some programmes they go directly into specialty training in ST1 and they do run-through training until the completion of that training programme and in other specialties they do what we call core training which can be two or three years, and then at the end-point of that core training, they can go on to choose to leave the training programme and work at that level in the health system. Again, it would be expected that they would be working under the supervision of a doctor who has a further qualifications and a certificate that gets them on to the specialist register. If they choose to continue into training they would reapply and they then enter higher specialty training and that can vary from between -- and a further three, four, sometimes five years.
Q. Okay, so you said there were various routes out. I think you mentioned the possibility of becoming an employed doctor which is stepping out of the training programme to do something somewhere else. What's the ultimate objective if one stays within the training programme?
A. So the ultimate objective is to achieve either a full

registration as a GP or as a consultant on the specialty register with the GMC and that gives an assurance that that doctor has achieved certain competencies, has knowledge and skills to enable them to practice independently.
Q. So effectively if you look at it -- we're interested obviously in neurosurgery, so if someone were on this journey towards becoming a consultant neurosurgeon which I think you a said consultancy is the objective if one stays in a certain path, if we could put it in that context someone might get an MBChB from university, yes?
A. Yes.
Q. And then they would do the two years of foundation?
A. Yes.
Q. And then they would go into further training after that. At what point would the surgical aspect kick in to that? Does that kick in at the higher training point or is that something -- if you were choosing to go down the surgical route, where does that start?
A. So for many doctors that choice has already started to formulate for them when they're at medical school and it can influence their choice of training programme but it would be post foundation they would enter into surgical training.
Q. Right, so after the FY2 they would do certain

activities, rotations whatever, FY1, FY2. They might still have the objective of becoming a surgeon, that would be relevant to that, but they would focus on surgery thereafter; is that correct?
A. Yes.
Q. And as regards the progression towards a consultant, we heard some evidence yesterday from the chief executive of the Royal College of Surgeons of Edinburgh and he tried to fit in, in his evidence, what his organisation might do to provide training and how that fits in with the various other parts of the system. And in many ways that's what we are trying to understand. One of the things he talked about was becoming a member of the college and becoming a fellow of the college and can you help us with where that sits in the progression that we've been talking about?
A. Sure. So the resident doctor in training would be competitively appointed on to a surgical training programme and they would then take up a clinical placement that was designed for the level of experience that they had, and to achieve the training milestones that they need.
And we have four sites across Scotland that we deliver neurosurgery training in as part of a national programme. It is not sustainable to deliver

in individual hospitals and the resident doctor in training wouldn't get all of the experience and exposure they needed if they were to stay in one space. The resident doctor in training would then go through the progression of training, the various milestones on the way, with opportunities for that progress to be reviewed by a panel of educators and almost like gateways that they would go through and at each of those gateways there would be demonstrations of that doctor's abilities and also evidence that the training environment was supporting them to achieve those capabilities.

Within the surgical curriculum they would then be supported in that early phase of training to undertake the membership exam for the College of Surgeons and they would get appropriate training and support, they would have study leave and time to be able to undertake the exam and then, with the exam and with progression on an achievement of competencies, they would progress to the final stages of training.

My understanding -- and I might need to check this -- is that the fellowship exam of the Royal College of Surgeons is one that's more of an exit exam. So it's done very much towards the end of training so that that doctor can demonstrate, both in written and a clinical exam, that they have the competencies that the college

expect that -- the college design the curriculum, we support the delivery of that. But alongside that, they're maintaining a portfolio throughout their training where they're documenting the procedures that they undertake, the skills and competencies that they demonstrate. But also how they are experienced in the workplace, so it's really important that we capture feedback on how the doctor is as a colleague, as well as how they are as a professional.

Q. Okay. Well, perhaps we'll get some of the details of the training at a later stage. That's very helpful. Just to pick up on a couple of aspects of that.

So the situation where someone has decided they want to go down the surgical route, they would be looking for a placement to be doing surgical work, they would then sit the member of the Royal College exams that we heard about. It seemed very much that that was sort of the beginning of the journey, if you like, as far as the Royal College was concerned but that there would then be continued training thereafter leading towards the fellowship being an exit exam and that would be the end of the training, as you've called it.

Is that broadly correct?

A. That's broadly correct to achieve a certificate of completion of training. Now that, of course, isn't

where learning stops. As doctors we expect every professional to continue their professional development and to evidence that through their appraisal.

Q. Yes, and if we were to revert again to the neurosurgical hypothesis that we were discussing, you mentioned the point at which someone would start to be looking for a place in a surgical training spot. At what point would someone start doing neurosurgery as a specialty if that was their ambition, what point in the journey? Would it be at that third year or would there be something that comes in at a later stage? I think you mentioned something about a specialist training?

A. So I would have to actually check. I'm uncertain, for neurosurgery, whether that's a run-through training programme or one that you enter post core training for surgery. So we can check that.

Q. So a run-through would be one that you would start from the third year and carry all the way through, is that right?

A. So run-through would start post F2.

THE CHAIR: Sorry, what?

A. Post foundation 2, sorry.

MR DAWSON: So that's foundation year 2?

A. Yes.

Q. So in foundation year 3 you would start the surgical

training. And in some disciplines that would run through and you would be in that discipline throughout?

A. So it would be specialty training year 1. We don't have a foundation training year 3, sorry, it is --

Q. Yes, year three of the training, but surgical training year 1?

A. But they may be graduates of more experience than that because they may have stepped away from trained post F2. So they're not necessarily all immediately after foundation.

Q. Well, let's just try to keep the hypothesis as simple as we can to try and understand the basic framework. But whether neurosurgery is or is not, there are some surgical programmes that would run through from the third year of training, the first year of surgical training, through to the completion. And there are others that would have some general surgical training and then would become specialists later; is that right?

A. So core surgical training and they would achieve more general skills across different programmes so that they were competent to enter into higher specialty training for different surgical specialties.

Q. And the expression that we came to at the beginning, the "registered doctor in training", what does the "registered" bit of that mean?

A. Resident.
Q. Resident doctor in training, okay. So on the hypothesis that we're discussing, the individual who is in training is working in a hospital environment. I think you mentioned something for neurosurgery about there being four different sites where that can be taken and the need to move to more than one, was that what you said?
A. Yes.
Q. So the four different sites are?
A. Ninewells, Aberdeen Royal Infirmary, the Queen Elizabeth and Edinburgh.
Q. Yes, so there's Edinburgh, Glasgow, Dundee and Aberdeen, basically. And is it therefore necessary within the training, certainly as it exists now, to work in a number of those; is that what you were saying?
A. Yes.
Q. So as to try and broaden the experience?
A. To broaden the experience and not all of the sites do all of the procedures.
Q. Yes, so there's a general broaden of experience where you get differences obviously from a different environment but also some hospitals may not offer certain surgeries, for example, that you would need to become proficient in to reach the end of the training?
A. Yes.

Q. With some hesitation, there's another aspect I'm going to ask you about which is, again, using your qualifications as an illustration. You're a fellow of the Royal College of Pathologists and Royal College of Physicians and it says "(medical microbiology)". I wanted to ask you -- obviously we're looking at surgical colleges largely, but I was interested to know what the difference is in between being what appears to be a general fellowship of the Royal College of Pathologists and a more specialist one for the Royal College of Physicians. Is that just because they operated differently, or is there a difference? Because one has medical microbiology and one does not.
A. So I wonder if that's a typing error in the statement because I'm a fellow of the Royal College of Pathologists (medical microbiology). So in my training to be a medical microbiologist under the curriculum of the College of Pathologists, I specialised in medical microbiology and went on and followed that curriculum and did those exams. So the fellowship --
Q. I see, so the fellowship exam is in medical microbiology for both?
A. Is in medical biology, yes.
Q. Yes, the reason I --
A. So, my fellowship of the Royal College of Physicians is an honorary fellowship that I was awarded about seven years ago for the work I have done. So I wouldn't practice under that. My clinical practice is under my fellowship of the Royal College of Pathologists.
Q. Understood and I think there may be differences depending on the field but is it the case that fellowship exams are taken in specific clinical fields; yours is medical microbiology?
A. For many colleges, yes. And there are also for some colleges specialty-specific exit exams as well as the fellowship. So it is a complicated landscape.
Q. I see. So the exit exams are not run by the college or are they run by the college?
A. So they're run by the college and you have to pass those exams if you're on a training programme to be able to achieve your certificate of completion of training.
Q. I see.
A. There are other routes to getting on the specialist register with the GMC and that involves presenting a portfolio of evidence of your clinical practice, which may or may not include having passed an exam.
Q. I see, and being on the specialist register with the GMC, what does that mean in terms of the progress that -- the progression that we've been talking about?
A. So when a doctor has completed their training and we have reviewed all of the evidence that they've presented, and that we've gathered from the clinical environment that they work, we can make a recommendation. That is called "outcome 6" in the annual review of competency progression and that means that that doctor has completed all elements of their training such that they are safe to practice as a day one consultant.
We then make that recommendation to the GMC and the college that they are awarded a certificate of training in that specialty and the GMC then have them recorded on their register under that specialty. So if you look up a doctor on the GMC register it will say: this doctor has or does not have an entry on the specialty register. And that registration will describe the specialty that they have evidenced completion of training in, it might be general practice, it might be neurosurgery, it might be medical microbiology.
Q. So just to get this right, the entry on the specialist register is an indication that the individual has completed their training in that discipline, if you like?
A. Yes.
Q. Okay, thank you. Then as far as becoming a consultant is concerned, does that then enable someone to apply to

become a consultant?
A. That enables somebody to apply to become a consultant.
Q. But doesn't make them automatically a consultant?
A. Not at all.
Q. Because alongside this, just to complicate it even further, are the various grades of doctor that one might see in a hospital which are really to do with their employment progression, as I understand it; is that right?
A. So if a doctor is in training their grades are a reflection of the competencies and skills that they've achieved and I think we've already described that the "resident doctor in training" title covers many different years and abilities and so we would also describe what stage of training that that doctor was at. But there are doctors who work outwith the training programme who might be referred to as an associate specialist, a locally employed doctor, a SAS doctor and they've all got different levels of experience, some of which are equivalent to, or approaching the equivalent to consultant, and indicate that they are safe for unsupervised practice. And others of them indicate that that doctor needs to work under the supervision of another clinician.
Q. So those people who you've mentioned step outwith the

training programme, there are other means by which they can illustrate competencies such as to be able to be licensed to carry out certain activities?
A. Licensed ... So "licence" is a tricky word because the doctor, once they've got full registration, also has a licence to practice but the licence to practice is within the skills and competencies that you can demonstrate that you have.
Q. Right. So you mentioned there, for example, being able to work unsupervised. Would you have to be licensed to do that?
A. You have to be licensed to practice clinically in the UK.
Q. Okay.
THE CHAIR: Mr Dawson, could I ask a question? I do so with some hesitation and it may be a product of my not noting the evidence correctly or just my misunderstanding but I'll try anyway.
When you were asked just now about the route to specialist registration with the GMC you referred to all of the evidence being reviewed and you referenced something called "we": we review all the evidence and can recommend something called "outcome 6". Should I understand that to be the organisation whom you're representing today?

A. Yes. So we convene panels called "annual review of competency" panels, and they've got representation from our deans, from the training programme directors and from the environment where doctors are working and they review the evidence that's been put forward.
THE CHAIR: Okay. Does it follow from that then that, at least viewed from the prism of today, your organisation is involved in quite a significant way in the process by way a doctor achieves specialist registration?
A. Yes.
THE CHAIR: Yes, thank you.
MR DAWSON: Thank you, sir. The post that you hold has changed slightly, I think, at least nominally, since the statement. In the statement you described yourself as the executive medical director of NHS Education for Scotland, is that right?
A. Yes.
Q. And that's a post you held I think until April this year?
A. Yes.
Q. And in April this year, as I understand it, there was a re-organisation in the way NHS Scotland conducts its business and NHS Education for Scotland was amalgamated into a new body with other existing bodies and NHS Education for Scotland is now part of that body; is that

correct?
A. Yes, it is.
Q. That body is Public Services Delivery Scotland, is that right?
A. That's right.
Q. And as I understand it, you are now one of two medical directors within that organisation?
A. That's correct.
Q. And your responsibilities, such as those that the Chair asked you about, remain the same as they were before; is that correct?
A. That's correct.
Q. And I think the position is that there is a period of calibration going on as to exactly how the various entities will work together going forward, is that right?
A. Yes.
Q. But ultimately your role as you described it and the services offered by NHS Education for Scotland continue to be the same now as they were before that change?
A. That's correct.
Q. So we can take it that the evidence that's in your statement and the various documents you provided still represent how the various services relating to the education of resident doctors in training and the

various other activities which the organisation pursues, they remain the same now as they were in the statement?
A. That's correct.
Q. Thank you. You've also held a number of other roles before in various different parts of the NHS and without needing to look at any of them specifically, they include, I think, being an associate and a deputy medical officer in NHS Highland and as it happens -- and you're an appropriate witness to ask this question to early in our hearings. Could you tell us what a medical director and a health board does, relatively succinctly if that's possible?
A. I'll try. So a medical director and a health board's primary responsibility is one of clinical governance of patient safety and professional assurance of the doctors that the health board employs. And they oversee the frameworks through which safe care is delivered to the population that that health board is responsible for.
Q. And are the doctors in the hospital answerable to the medical director?
A. The doctors who are employed by the health board work within the clinical governance framework of that health board. Different doctors have different employment contracts but wherever they are delivering the care, they have a duty to work within the clinical governance

frameworks in that environment.
I'm not trying to evade the question of: are they responsible to the medical director? So the resident doctors in training, for example, I would be expecting them to work, whether they were in a local education provider, whether that was their employer or if I was their employer, within those frameworks. But for those doctors I am the responsible officer, not the medical director who is governing the clinical governance systems in that health board.
But for doctors who are employed by the health board and are not in training, they have a relationship via the responsible officer status with their medical director and the responsible officer status puts a duty on that individual to ensure that the doctors are working in a safe, supported environment that has strong clinical governance frameworks and has systems in place for learning to be continually improving clinical care and patient safety.
Q. Right. So just to be clear, the medical director's functions relate to the being in charge of the clinical governance systems, yes?
A. Yes.
Q. And if a doctor is working, say, in a hospital in a health board but is a doctor in training, you are

their medical director?
A. I'm the responsible officer.
Q. Yes, and the responsible officer effectively is someone who is responsible for discharging those clinical governance functions in law?
A. Yes.
Q. I think you mention in fact in your statement the enactment or regulations by which that came in and we've heard a little bit about that already. But as far as other doctors who are working in a hospital are concerned, the responsible officer to whom they are accountable under these clinical governance frameworks would be the medical director of that board or whatever the employer is?
A. Yes.
Q. Thank you. You also held the post of an associate and deputy medical director, I think. Are these posts which may or may not exist within a health board in order to assist the medical director in the discharge of his or her functions?
A. Yes, it's exactly that. It's in an assistant to delivering the function. So in my role as deputy medical director in NHS Highland I had responsibility for the acute clinical care delivery, so that care that was delivered largely within the hospital setting.

I had a counterpart who had that responsibility for primary care, so largely the care that was delivered in general practice and the community. But of course there is an interface between both of those roles and a direct report to the medical director. But that -- again, discharging effective clinical governance systems and to ensure patient safety is the key role.
Q. Thank you. And if I could look at it going in the opposite direction, if you like. Does the responsible officer have obligations to report upwards if you like to other people within the health board or beyond?
A. So in terms of the responsible officer function, the chief medical officer in Scotland is the high-level RO for all responsible officers in Scotland. Of course, as the medical director, in our role you have our responsibility to your chief executive as the accountable officer for the organisation with which you're employed and so those two relationships are very key and critical, particularly around the systems in which we deliver safe patient care.
Q. And I think as it happens you also worked as a senior medical officer in the Scottish Government health workforce directorate; is that correct?
A. It is correct.
Q. So again, it might be helpful just to orientate

ourselves around that. That is effectively the directorate through which, as I understand it, certain healthcare services are delivered by the Scottish Government, is that right?

A. So the health workforce department is the directorate that has an oversight of -- and in the role I was doing the numbers of doctors in training and their specialties and where we would be having those doctors in training, as it has other functions around ensuring that there are adequate revalidation processes across Scotland. It also looks at the funding of medical education and training, both at undergraduate and postgraduate levels. And I'm sure it has a multiplicity of other roles.

Q. Does it sit within the Health and Social Care directorate or is it separate?

A. It sits within the Health and Social Care, yes.

Q. So it's a sub-directorate of the main directorate, I understand. Where does the chief medical officer sit within that? Did you work for the chief medical officer or is the chief medical officer separate to that?

A. So I worked for the director of health workforce with a professional line of sight to the chief medical officer at the time.

Q. Right, is there a separate directorate for the chief medical officer?

A. Yes, there is.

Q. That was my understanding, thank you. And you were also, at one stage, the national lead for patient safety for the Scottish Government.

A. Yes.

Q. What did that role entail? If you can, in a relatively simple way, could you explain where that sits in the architecture?

A. So I worked at that point for the quality directorate. I don't think that exists any more within the Scottish Government the Health and Social Care directorate. And my role and remit in that space was really around the interface of the Scottish patient safety programme, with other key areas where we wanted to make improvements to patient safety, such as reducing healthcare-associated infection much but also looking at other areas such as reducing venous thromboembolism such that we could be continually improving care for patients.

Q. Thank you. Moving then back to the respond -- your role and the responsibilities of what was NHS Education for Scotland, now part of Public Services Delivery Scotland. One of the other aspects that you mentioned -- I think you mentioned, but correct me if I'm wrong -- that there are various different organisations involved in the various different parts of the setting standards, the

delivery of training, and the operation of delivery of training. So if one were to hypothesise again, we're back in our progression of the training programme, what are the respective roles for those various different things for, respectively, the GMC, now Public Services Delivery Scotland, and, say, a health board if we're talking about someone who is working within a hospital?

A. Okay. So talking now and not at the time of the Inquiry, the General Medical Council now sets the standards for education and training across the UK. It also --

Q. Would it be possible for me -- I don't mean to be rude, but if I could just interrupt you because there are bits you are going to say that are of particular interest. So if we just say the GMC sets the standards. When you say "standards", you mention I think in your statement you make reference to a section 34H of the Medical Act which sets out, without the need to go to it, very broad responsibilities. It's the Act which basically sets up the General Medical Council and this is one of its subsidiary provisions relating to medical education. And it sets out various high-level responsibilities of the General Medical Council in that regard, such that there would be various high-level steps that need to be taken.

So as regards setting standards, in a practical sense, what is it that the GMC does? Do they just say: everybody needs to do everything that we say? Or do they actually write down what the different standards are? And how particularised are those standards? Are they standards that are abstract concepts that apply to everyone or are they done by field, or how does that work in a broad sense?

A. So they're very specific standards around medical education and training, and there is a document that we provided to you which is standards for excellence. And they are not in any way abstract and they make reference, through five different theme areas, around what organisations must do and occasionally there is the use of the word "should", but in that document they're very clear that educational standards are there in service of patients and that there must be a very clear and strong distinction made between the quality of patient care and the quality of medical education delivery.

And I think it would be really important to note for this Inquiry that the medical training is done well, to a high standard. It is part of our patient safety architecture into the future because it is by those standards that we've got clarity of what is expected,

we've got definitions of outcomes that we can measure against and that enables us to (a) know if a doctor is progressing through training, but also to look at an environment where a doctor is learning and know if that is in need of improvement or support or if it's functioning well.

Q. And are those standards directed in particular at anyone, at doctors in training, or the deliverers of the training, or the architects of the training, or everybody?

A. So we all have a role within those standards and so Good Medical Practice is the standard document by which we, as registered professionals, must align and that is applicable for medical students as well as registered doctors within the standards for excellence. The GMC mark out really clear expectations both of statutory education bodies -- NES, now PSD, is Scotland's statutory education body -- and what we must do in terms of our quality management and support of medical education and training. But it's also really clear about what local education providers should do/must do in terms of providing a supportive environment both for the resident doctors in training but also in terms of those who are delivering education as clinical or educational supervisors.

There's also expectations mapped out by the GMC for universities and colleges in how they develop and design the curriculum such that patient safety is at the heart of all of those documents.

Q. Thank you. And I knew that we'd run into this at some point, but I'm going to try to keep up with the acronyms, but just to be clear, when you refer to "NES, now PSD" what that means is NHS Education for Scotland, now Public Services Delivery Scotland?

A. Yes.

Q. I think there may be more of those to come.

A. I'm so sorry.

Q. Not at all. So we got to the point of the standards being set by the GMC. Then there are other bodies, I think, that are involved in the delivery of the training but also in the creation of the training and the oversight of the training. Can you explain which bodies are involved in those aspects?

A. So NHS Education for Scotland, now Public Services Delivery Scotland is the statutory education body for Scotland. As I've said already, each devolved nation has a statutory education body and their function is to ensure that training of doctors meets the GMC standards and that there are systems in place to ensure that those standards are being met and to be able to detect if we think they are not being met.

Q. So just to be clear though, is it the case that you would then take the standards and then you create means by which those standards can be delivered but you don't actually do the delivery, is that right?

A. That's right.

Q. But also your function is to oversee that the delivery is being done to a standard that you are policing effectively, is that right?

A. Yes, I might not use the phrase "policing", but yes we oversee and triangulate many different levels of data that we receive, both from the local education providers, around how they are delivering training. We get feedback from the resident doctors in training, both through surveys but also by having an open culture where we invite doctors in training to let us know if they have got experiences, good or bad. And we also monitor the progression of our doctors in training both across programmes, across regions and looking for signals all the time for areas where we might be more curious as to what is happening in a training environment such that we can work in partnership with that environment to ensure that they can deliver to the standards. And where there are situations where that is challenging, we have a mechanism where we can escalate that training environment to the GMC under a system called "enhanced monitoring", and that enables us to provide more support and to look for more data and ensure improvement is happening in a much more active way than just that system scanning that we go on.

Q. So you're overseeing both -- I think you used the expression earlier "local education provider". I think that might be an acronym as well, but we avoid it but I've seen the acronym in the statement. That would be, for example, a hospital delivering training to a doctor in training, yes?

A. Yes.

Q. And you are overseeing both those bodies but you're also overseeing the resident doctors in training as well?

A. So we are overseeing the resident doctors in training in how they are progressing and the local education provider -- I don't think it's an acronym, I think it's a description of where training takes place, a general practice is a local education provider. A hospital is, as is a health board. But also we look down into the granular detail of the different clinical environments.

Q. When you say "clinical environments", what do you mean by that?

A. So that can mean a ward or a clinic area.

Q. Right, so in the sense that you've got a granular

operation and trying to make sure everything that is being delivered is supporting the training in the best way it can be?

A. With the focus of patient safety at the end, yes.

Q. Yes. So what we have said about the local organisation or hospital would be responsible for the delivery, but Public Services Delivery Scotland is not responsible for the delivery, is that correct? Other than overseeing it?

A. So we're not responsible for the delivery of the clinical education in the clinical environment. So that is very much investment the responsibility of that clinical area and for that to be done within the bounds, as we've described already, of their standards and particularly around clinical governance. The reason I'm hesitating slightly is that we do deliver in terms of specialist training days for resident doctors in training. We also have specialist environments such as the NHS Scotland Academy where the doctors can go for immersive training and we also develop education resources that the doctors in training can access. But in terms of the hands-on, clinical skills then that would not be our -- what we do.

Q. Thank you. And you've helpfully told us I think NHS Education for Scotland came into being in 2002, is that

right?

A. Yes.

Q. And that came into being as a result of, as we've encountered more recently I think, a number of bodies being amalgamated together in a single body; is that correct?

A. Mm-hmm.

Q. And the bodies that existed previously were bodies which were responsible for overseeing education in various different professional fields, is that right?

A. Yes.

Q. I think they covered -- there was the postgraduate medical and dental education -- Scottish Council for Postgraduate Medical and Dental Education, which was the one that was particularly involved with doctors --

A. Yes.

Q. -- and dentists. Whereas there were other bodies that were responsible for, I think, nursing, midwifery and pharmacy. There being a pharmacy one, a midwifery and the three came together into one body, is that right?

A. Yes, that's right.

Q. And I think you've tried -- it's appreciated -- to help us with understanding why that happened at that time. My impression from the statement is that it was an administrative decision and a decision based around

there being perceived to be a value in bringing together and centralising the education of these professional bodies in one place, is that right?

A. That is my understanding.

Q. Do I take from that -- and I understand that's your position looking back and trying to be helpful to us -- that there wasn't any sense of dissatisfaction with the way that things worked previously, other than there would be a benefit in centralisation?

A. I can't answer that question, I'm really sorry.

Q. And as far as -- one of the aspects of the statement that's of interest to us is what it is that your organisation, which I'm taking -- let's call it NHS Education for Scotland -- could tell us about that period? Because obviously the period we're interested in although 2002 onwards is of interest to us, we're interested in the period before that back to 1995 when the Scottish Council for Postgraduate Medical and Dental Education would have been the body performing this sort of function. You said that you don't have access to any documents from that body; is that right?

A. That's right.

Q. And have told us that they have been destroyed in accordance with a document retention process. Is that right?

A. That is my understanding.

Q. Yes. Are you, quite reasonably, assuming that that is the case because they should have been in accordance with those procedures or do you know that there are no documents?

A. It's my understanding that that is what would have happened in accordance with the retention policy. I do not know that for a fact.

Q. It's just the reason I ask is because it may well be that your organisation works differently from others but it has been our experience so far that there have been assumptions sometimes made that because of the existing government guidelines or retention schedules that there won't be documents. But in fact, on further inspection, there are in fact documents that have been retained beyond the retention schedule or scheme deadlines. So what I'd be interested in knowing -- and I know it wouldn't be your job, someone within your organisation -- as to whether one can entertain the possibility that they might exist despite those and whether searches could be done to try to make sure that there aren't?

A. Absolutely, if that's helpful to the Inquiry.

Q. Yes, it certainly is, simply because you also have offered us no indication -- not meant as a criticism,

you just don't know, I don't think -- as to where any documents pertaining to that body might be if they do exist. One place that we have tried to look for documents is in the national archives and we continue to do that but it would not be uncommon in our experience for organisations today to assume that documents don't exist but in fact for documents to be turned up somewhere. So if that would be something that your organisation would be prepared to do, it would be extremely helpful because obviously we're interested in that earlier period as well and we accept there are limitations on what certainly you can tell us about it.

I think you also helpfully told us there are other people who may still be available, including one particular gentleman who may have worked for the previous body who held a senior position in NHS Education for Scotland about the time of the transition, is that right? Is that your understanding?

A. Yes, that's my understanding.

Q. I think also, as I understand it, there are other individuals who have held senior positions who have gone on to hold other positions in other places. One, for example, was Caroline Lamb. As I understand it, she held a senior position in your organisation. We are, in fact, hearing from her in a different capacity later on

in this Inquiry and so there may also be people who can help, who perhaps were nearer those events. Is that correct; is my understanding correct?

A. Yes, that would be correct.

Q. Thank you very much indeed. As far as the way in which the educational provision is delivered, there are some phrases which are no doubt very familiar to you which float about in the statement which I struggled with slightly. There is a mention, for example, of there being a curriculum or curricula that play an important role. Could you tell us a bit about that?

A. Yes, so each specialty has a curriculum that is described by the relevant Royal College and that document describes the skills, competencies and knowledge that a doctor needs to acquire to become a specialist in that specialty. So our role is around the delivery of that --

Q. So --

A. -- curriculum.

Q. -- just to be clear, the curriculum comes from the GMC, is that right?

A. No so the curriculum comes from the Royal College and then the Royal College presents those documents to the GMC.

Q. Yes.

A. And the GMC then approves them. There's a process whereby they have a curriculum oversight group and the GMC is always interested in how are these going to ensure safe standards of care and patient safety but also are they deliverable and fit for purpose for our health system.

Q. There's another concept in what I've seen "competency frameworks". What are they?

A. So they are part of a curriculum document. So they would be describing what it is we would expect a doctor to be able to do and how they would demonstrate those either technical or clinical skills.

Q. Okay, and as far as -- could you give an example of the sort of area, the breadth of area, if you like, or a particular area that a curriculum would exist for?

A. So for each of the, I think it's 67 specialties that we have across the UK, they would all have their own curriculum document.

Q. So would neurosurgery be one, for example?

A. Yes.

Q. And then a competency framework, how would that work within the neurosurgical curriculum?

A. So it would almost bring to life certain aspects that an educational environment would be looking at both in terms of what it could deliver and how it would assess

a resident doctor in training to have achieved those skills, acknowledges, behaviours. And so it very much distils out from the curriculum what it is we might expect to see.

Q. And are -- who's responsible for the creation of the competency frameworks?

A. That would be the colleges.

Q. Sorry, say that again?

A. The colleges.

Q. The colleges, right. So you would then be using these curricula and competency frameworks and your job is try and work out a way that can be delivered, not in the immediate sense, but to provide mechanisms by which the education can flow and be used in a hospital or whatever at the end of the day, is that right?

A. That's right.

THE CHAIR: Just -- I think you possibly clarified that in your question, Mr Dawson, because I was a little confused by your reference to you delivering the curriculum and the position of the local education provider who delivers it as well but in a more immediate sense. But you're the kind of bridge in between, you facilitate the process by which the curriculum filters down to the provider of education?

A. That's correct.

MR DAWSON: As far as the structures are concerned, this is definitely an area we've struggled with as to the various different positions and I'm not sure about the extent to which it's affected by you helpfully having provided evidence to us about the period before NHS Education for Scotland and after. But there are various, it would appear, important roles in the delivery of this overarching mechanism and in that, in some place feature deans and a deanery. I understand that something called the "all Scotland Deanery" may have come about as part of NHS Education for Scotland's activities in around 2014 which suggests there was some sort of change. Beyond that, it would be very helpful if you could try to help us understand how the deaneries and deans worked and work after that date, in particular it would appear there may be deans sort of on both sides of the fence in the recipient and the deliverers of training and in those who provide the training. So if you could try to give us a sort of tutorial, if you like, on how that works that would be extremely helpful.

A. I will do my best.

Q. Thank you.

A. So if we look back to 2009/10 in Scotland there were four deaneries, the east, the north, the south east and the west. And those deaneries operated within the NHS

Education for Scotland structures and the deans oversaw, within the geographical area that they were based, all of the training and education across all of the programmes in that area.

Q. So just to clarify, Dundee would be in the East, Tayside, yes?

A. Yes.

Q. Thank you.

A. And that would have been one of the smaller deaneries in Scotland.

Q. Okay, so that wouldn't cover Edinburgh, for example, then?

A. No, that would be south east.

Q. Thank you. Please carry on.

A. And within the deanery structure the deans, at that point, would have had associate postgraduate deans who had specific programmes that they were responsible for in that region and there would be a role called a "training programme director" which is getting much closer to where the individual resident doctors in training are and they look after a specific rather programme and they support the trainee primarily but also ensure that the educational and clinical supervisor who are employed by the health board, the local education provider, know what it is they are supposed to

be training. Do they understand what the curriculum is for that specialty, have they understood the skills and competencies those doctors have and are they properly supported? So that would have been the structure as it was in --

Q. So just to be clear, all of those different roles going down from the dean, associate dean and below that for a specific course, they were all within the NHS Education for Scotland structure and then once you got down to the most local part you were engaging with I think you called it an educational supervisor, was that right?

A. Educational supervisor or clinical supervisor.

THE CHAIR: Sorry, was it one or the other or both?

A. They're both. They're different roles.

MR DAWSON: And again, I don't know whether there's difference in time. You were telling us about the system that existed around about 2009/10. The change in 2014, I think, was that they stopped having the four centres and became an all-Scotland operation, a centralisation of the functions.

A. Yes.

Q. But as far as more historically is concerned can you help us as to whether that deanery-type structure existed back to 1995 from 2009/10, or was that something

that was -- how far back can you help us?

A. I don't know. I'm really sorry, but we can find out.

Q. Okay, well, I have certainly seen mention of there being postgraduate dean and things at an earlier stage than that, but we can certainly look into that. So as far as the systems are concerned, was there always, at the ground level if you like, the delivery person, that is a supervisor of one kind or other, is that right?

A. Yes.

Q. So the supervisor might be someone like a consultant surgeon who is providing training in a theatre to a surgeon in training, a resident doctor in training who is doing the surgical course; is that correct?

A. That's correct.

Q. And you differentiated between two types of supervisor which I think there are -- I think there's a clinical supervisor and an educational supervisor, is that right?

A. That's correct.

Q. And the clinical supervisor would be the one responsible for the sort of thing I just described I think which would be providing technical education and skills to someone, say, in surgery to carry out a particular procedure, something like that, is that right?

A. That's correct.

Q. That would be why, perhaps, people are now required to

work in different hospitals because they wouldn't have exposure to the different procedures, as every hospital might not offer the ones that you need, as we said earlier, is that right?

A. Yes.

Q. What about educational supervisor, what is that?

A. So, the educational supervisor sits in a different space in the educational journey and is looking not just at how the doctor is acquiring those specific technical skills but how are they progressing through their educational journey. And it's quite important to have a different person in that relationship because it gives the resident doctor in training an opportunity, if they've got worries or concerns, to have somebody else that they can talk to, reflect with and I think that that is quite important.

Q. Is it essential that someone have different people in those two roles?

A. So it's an interesting question because we do have some programmes where they are delivered by the same person but I think we must always be really aware in that relationship that the resident doctor in training may have an area where they are not necessarily feeling that they could be supported and that's why we have our training programme directors and they have a very strong

relationship with the resident doctors in training and they would be seen, again, as somebody else that the resident doctor in training could look to both for learning but also if there were something going on. But largely we do try and have the separate roles. And a consultant could be a clinical supervisor for one doctor and an educational supervisor for another doctor, so they could hold roles but not be for the same person.

Q. But one can imagine, as I think you said, there could be a value in the separation in the sense that it might be useful to have two different people and two different perspectives on things in two different areas; is that the thinking behind that?

A. That is the thinking.

Q. And the role that you mentioned as being a potential third person you could go to, or second person if it was the same person, what was that role?

A. The training programme director.

Q. Right, and is that someone within the -- I was going to use the acronym there, the NHS Education for Scotland structure, or is that someone within say the hospital structure?

A. So that is a doctor who we employ through NHS Education for Scotland on, generally, a service level agreement basis with whoever their lead employer is.

Q. So, I remember this. It is something like you pay a part of their salary or something like that for them to perform that function for you but they are otherwise working as a consultant or something like that in the hospital, let's say, is that right?

A. That's right, yes.

MR DAWSON: Okay, that's excellent. Sir, that would be a convenient moment for a break.

THE CHAIR: Yes. We'll stop now for about 15 minutes. For the sake of good order and discipline we ask witnesses not to discuss their evidence while the break is going on and we'll come back in about 15 minutes, if that's convenient. Thank you.

(3.15 pm)

(A short break)

(3.30 pm)

THE CHAIR: Thank you, Professor. We are ready to resume, I think, Mr Dawson.

MR DAWSON: Thank you very much, sir. We were talking about clinical and educational supervisors and I was interested to try to ask you some more broad questions about the functions and remit of NHS Education for Scotland specifically because I'm interested in the period from 2002 but if there's any reflection you can give on the earlier period that be helpful.

You've explained so far aspects of the role of NHS Education for Scotland but in the specific context of the clinical and education supervisors, did NHS Education for Scotland have a role in overseeing, monitoring, regulating them to an extent in that function?

A. So NHS Education for Scotland's role in relation to clinical and educational supervision was to provide training for those individuals who were undertaking those roles. And that training has developed over time.

I think you'll see from the evidence that the General Medical Council became very interested in the role of clinical and educational supervisor such that they wanted to put much stricter boundaries around that role and expectations and so with that came a need to revise the training. So the training that NHS Education for Scotland delivered through the Scots courses was seen across the UK as very high standard training but it needed to be developed and adapted to support clinical and educational supervisors to the new standards.

Q. So just to tie it into the other evidence. NHS Education for Scotland had an oversight function of the local deliverers of training and of the resident doctors in training and it provided training to clinical and educational supervisors to undertake their function but

it did not oversee them in the same way, is that right?
A. That's correct, that responsibility lies with the local education provider and the health board.
Q. Yes, I was going to ask you because frequently throughout the statement, when asked questions around this area, and in particular the possibility that NHS Education for Scotland could have become aware of or done something about complaints related to Mr Eljamel in the broader sense, concerns, you say I think that that would be a matter for the employer, it would be a matter of the employment relationship rather than something that was in any way really in NHS Education for Scotland's responsibility?
A. Yes, that's correct.
Q. You do, however, say -- and I think you mentioned it earlier in our conversation about the three potential people someone could go to -- that it would be possible for concerns of that nature to come to the attention of people working for NHS Education for Scotland carrying out their various functions. It might, for example, I think be possible for a resident doctor in training to go to their connection within NHS Education for Scotland to say: the training I'm getting is not what I was expecting or I'm struggling with aspects of it. I think you told us about that a moment ago. So that would have

been a mechanism by which that could have come to the attention much someone working for NHS Education for Scotland, is that feasible?
A. So that is feasible but we've got no evidence that that happened.
Q. In Mr Eljamel's case?
A. Yes.
Q. I'm just talking here about the systems. But in such cases, what would it be likely in that hypothesis that NHS Education for Scotland would have done, given its limited regulatory or oversight role over a supervisor? Would it have reported somewhere else is really what I'm getting to?
A. So I can talk to what I would do now but I can't talk to what would have happened then. So we do become aware of situations in health boards and clinical areas and sometimes in general practices because of the information that comes to us from resident doctors in training via their training programme director or associate postgraduate dean, so the very first thing that we do in that situation is ensure that the resident doctor is safe and that they are not coming to harm.
And then we set about triangulating the information and that often includes having conversations with my equivalent in a health board or with one of my deans or

associate postgraduate deans having discussions with the clinical director or associate medical director. What we would then do is ascertain whether we would need to intervene at all. Sometimes the information we get from resident doctors in training necessitates that we go and visit the educational environment and meet with other colleagues.
At the whole system it's really important that the doctor who has raised the concern feels safe in having done so and feels that they are doing the right thing. There's been a culture over years within the medical profession that perhaps speaking out isn't the right thing to do. So we are trying to ensure, through all of our systems and processes, that speaking out is absolutely the right thing to do, even if, on further investigation, that there's nothing to find because a resident doctor speaking out takes a lot of energy, it takes a lot of bravery and it's really important that that's recognised.
We have situations live at the moment where concerns have been brought to us by resident doctors in training and they have resulted in interventions from us in partnership with the health board to improve the learning environment and I would say improve outcomes for patients in doing that.

Q. Okay, thank you. And if we stick to what you know about which is how things would work today, would that reporting route, if you like, by a resident doctor in training cover situations in which the resident doctor was being bullied by a superior?
A. Yes, absolutely.
Q. Would it cover situations in which the resident doctor in training was being intimidated by a superior?
A. Yes.
Q. Would it cover situations in which the resident doctor in training felt that there was inadequate supervision of their medical work by their supervisor?
A. Yes, it would.
Q. Would it include situations in which the resident doctor in training felt that the workload being imposed upon them was excessive?
A. Yes, it would.
Q. Would it include circumstances in which there were concerns about the supervisor, or a consultant working higher up, not being sufficiently present in the interests of patients for surgeries or other medical treatment?
A. Yes, we would want to know about all of those things.
Q. Okay. And would it include circumstances in which there were concerns about the way in which other systems in

the hospital were operating? So, for example, one thing you touched on in the statement which sounds like a sort of PhD thesis itself is the relationship between clinical governance and educational governance which sounds like a fascinating topic, but, for example, it might be the case that a resident doctor in training would come to you or one of your colleagues because there had been a failure in their ability to escalate it within the hospital systems. Would that be something that might happen?

A. Yes, that is something that does happen.

Q. Yes, as an outlet, if you like, because the systems that are meant to exist may not operate sufficiently?

A. Yes.

Q. You said a moment ago, I think, that there had been a historically -- and you're a long-standing medical professional yourself -- a culture of not speaking up in the medical profession. Is that something which is borne out of your own professional experience or is that now, within the medical profession, widely accepted?

A. So I think if we look back at why the changes have happened across medical education and training from a time where colleagues were trained in more of an apprenticeship model in a local system and there was a reliance perhaps on patronage and local relationships,

that culture of potentially a lack of externality might have created an environment where it might not have felt safe to speak up if you saw or experienced some of the elements that you described just a moment ago.

I think that has been recognised by us as a profession, by our regulator and it's why the standards have not only come into place but been strengthened and then been sat with the GMC such that the importance of providing a safe, structured, standard-led environment for medical education and training and that absolute link to patient safety.

And I think that is, in itself, an acknowledgement that the way we were as a profession isn't the way we are now. I still think that culture is a challenging thing to change and so we have to be really, really intentional to ensure that our resident doctors in training know they are supported. I myself went to an event with resident doctors in training only last week to be there in person, to let those doctors know that if they are experiencing anything in terms of bullying, undermining, seeing things that they don't think are quite right, that they have not only an expectation but a duty to speak out and that we want to hear. Because it's only through hearing and knowing of those resident doctors in training's experience that

we can support making things better and we very much see our role in what was NHS Education for Scotland, now PSDS, as supporting clinical environments to improve and supporting structures and frameworks such that it is unacceptable for bullying and undermining, sexual misconduct, people working outwith their competency. So we see that as a very important role of educational governance.

Q. Okay, but two aspects of the evidence you've given that I just wanted to try to -- if you could help us orient in time a bit as to when things changed. One, you talked about the GMC taking a greater interest in clinical educational supervisors. Can you orientate us roughly when that was happening? I know you've provided some information, but just for the information of people listening.

A. So there was a significant piece of work undertaken by the GMC to look at the role of the clinical and educational supervisor and the importance of that role and how those colleagues were selected, trained and supported such that they built the "recognition of trainers" framework and that was launched -- and I would have to back to my notes and I haven't taken my folder with me, but I think it was launched in 2014 and implemented in 2015. And at that point all of the

health boards and the universities had to identify colleagues in key educational roles. They had to demonstrate that those colleagues had been selected, that they had the time to do the role and that they were trained to do the role and that they had a full understanding of what that role was.

And then I think, really importantly, that they were appraised in that role annually. So they had to bring evidence of being able to do the role and what the feedback of them in that role is and that's part of our revalidation and appraisal process.

Q. Yes and was that the responsibility of NHS Education for Scotland or did that sit somewhere else?

A. So our responsibility in that space was to provide the training but also to hold the register of the doctors in Scotland who have those recognition of trainer roles.

Q. But the revalidation and appraisal process is someone else's responsibility?

A. That's the responsibility of the employing health board.

Q. Thank you. And the other aspect that you've been telling us about that I wonder if we can orientate in time, you mentioned there being a shift between what we have now which is an educational system which seeks to deliver care in a more patient-focused way and you contrasted that with an older system which I think you

said was more locally delivered, involved apprenticeships and sometimes patronage. You do mention that in your statement as there being an older system and a system which attempts to be more structured and inclusive and patient-orientated. Can you help us with -- there are various changes happening in your statement, various changes of bodies, various regulations coming in. Is it possible to pinpoint when that change started to happen or over what period it happened and what particular developments were associated with it?

A. So in terms of -- I think one of the key areas was when the colleges were working together to ensure that they were describing standards. The Postgraduate Medical and Education Training Board came into being I think in about 2007, and that was the first time there was a national oversight of the quality of medical education and training and that assessment that a doctor had achieved completion of training. And I think they awarded a certificate of specialty training completion. The acronyms get me too.

That entity was present, I think until 2010, when the Medical Act was revised to sit the function of educational standards with the GMC and it has been enduringly with the GMC since then. And as I described

earlier on this afternoon, I think there has been a very strong mechanism for ensuring that there's a connection between the educational environment that a doctor trains in, the clinical environment that a doctor practices in and that role of the GMC both in registering doctors but also in overseeing the fitness to practice. So that bringing together I think has strengthened and formalised the system.

Q. So that change in approach from 2007 to the training environment, you're saying I think is indicative or a part of a wider change in attitude to the way that medicine should be delivered, is that correct?

A. Yeah, I think that is what I'm saying.

Q. Thank you. In your statement -- we can go to it if you need to -- you were telling us a moment ago about a circumstance in which, at least today, issues being experienced by a resident doctor in training could be escalated or brought up within your system. One of the things we're interested in asking about and you've provided some useful information about was the extent to which information could be shared amongst agencies or between agencies which were indicative of concerns about certain practices or concerns about other things that were going on in a hospital, let's say.

And you tell us about -- if we can just go to it

actually, it's paragraph 10.7, please. You tell us there:

"In 2013, a public inquiry (Francis) about a serious failure of a healthcare system in England made a number of recommendations. One of these was to improve intelligence sharing within and between national agencies. This is to allow earlier identification of, and response to, the signs of a potentially serious system failure. In response to this, the Sharing Intelligence for Health and Care Group was established in 2014 which has resulted in much better sharing and consideration of key pieces of data and information by the Scotland-wide agencies involved. These agencies are now better prepared to take additional action, when this is required. The Sharing Intelligence for Health and Care Group inaugural report -- May 2016 has been provided ..."

And under paragraph 10.8, you say that NHS Education for Scotland and Healthcare Improvement Scotland:

"... co-lead the Sharing Intelligence for Health and Care Network. This is a network of organisations working in health and social care to connect, share insights, and develop best practices in the use of data and intelligence. Its primary aim is to enhance the quality, safety, and effectiveness of health and care

services by promoting informed decision-making through better access to and understanding of data.

And you mention the report.

I think that may be a reference to the Mid Staffs Inquiry which was delivered by Sir Robert Francis. This is an area of interest to us about the extent to which data which is held within individual silos, when put together might give a different or fuller picture of problems occurring. And it was interesting to know NHS Education for Scotland and I presume the new body in Healthcare Improvement Scotland co-lead the health and care network.

What are the sort of prevalent attitudes now around sharing information or to try to achieve various aims that have been set out there? And in that regard, what role does the network play in trying to promote that objective?

A. Thank you. So the network that exists in Scotland is formed of the regulators who are based in Scotland, so that would be the GMC, the NMC, we've representatives from the General Dental Council, Pharmacy Council, Ophthalmic Council, as well as the Care Inspectorate, Mental Welfare Commission, NES, HIS, the Audit Scotland and the SPSO. And what they do together is share information that would be of interest to the other

parties, exactly as you say, to try and form a bigger picture of what is going on across the health and care network.

And then the network discusses data or information that is brought to that network and considers whether, as a network, anything needs to be done differently or if responsibility can rest with the relevant party who brought forward the information.

What we have seen in that network is opportunities to see potential areas earlier, perhaps, and to escalate them through the chief executives of Healthcare Improvement Scotland and what was NHS Education for Scotland for additional support. The network is, again, continually reviewing what it does and its place in the Scottish system to ensure that it is not overstating its aims but also acting to the Terms of Reference that it has.

Q. Okay, thank you for that. I was interested to ask you a few questions, without getting into any level of detail at this time, about the sorts of attitudes towards training that might have developed under the more sophisticated system of delivering training to resident doctors.

It is a phrase that we've seen as regards the way that surgical training might work, that we've come

across, which is perhaps -- you may or may not recognise it -- it may be redolent of an older system of medical training, if you like, if one can even call it that, there is what one call a "see one, do one, teach one" model which is redolent of a sort of system of quite rudimentary medical education. Is that something that you would recognise as being part of the sort of older system where busy surgeons would expect their resident doctors in training at that time to pick things up very quickly and there was perhaps inadequate attention to their needs and whether they had sufficiently understood what they were now being expected to do?

A. So I can't talk to that but what I could say is that isn't how we would educate and train doctors now.

Q. Yes. And I suppose, to some extent, you have recognised that there has been a significant shift and the needs of the resident doctor, for example, I think you say in your statement may vary considerably from one to the next and the idea of having a sort of "one size fits all" model is very much the opposite of the approach I think you would take; is that correct?

A. That would be correct.

Q. Just in terms of the types of training that are delivered, to be clear -- and again, I'm afraid I'll have to put it into a surgical context because

that's useful for us -- is the training that you facilitate the delivery of a full range of medical training for a resident doctor? So we heard yesterday in a slightly different context about training being delivered by the Royal College in a technical context -- this is surgery, of course -- and a non-technical context. And we also heard about the importance placed by the Royal College of Surgeons of Edinburgh on matters that would not perhaps traditionally be associated with surgery, how to do the surgeries and that sort of thing, but other types of qualities that they would wish to promote and indeed, a considerable amount of work being done in that area by the Royal College. And there was mention of the importance of training, including the importance of candour, and probity, and that sort of thing, communication. We talked a little bit with a witness this morning about the importance of being trauma-informed with patients and that sort of thing. Without getting into the specifics, does your remit cover delivery of training across all of those areas?

A. Yes, it does.

Q. And is it correct to say, as we understood, that there has been an increased emphasis in recent years on those non-technical skills?

A. I would say that there has been a significant increase

on the emphasis on the non-technical skills because what we know is that somebody can be technically extremely proficient but if they don't create a culture around them of curiosity, challenge, safe enquiry, then actually that's not a safe environment, either for patients to receive care or for resident doctors to train. So we see that as really, really critical in the training.

Q. Thank you. One aspect that's been emphasised by a number of witnesses so far as being a very important part, certainly to patients, of medical care is the importance of keeping and retaining good medical records. I could imagine that that could be the sort of thing that's thought of as an accessory to actual medical practice. Is that the sort of thing you deliver training in, or help facilitate training in?

A. So the keeping of good records is a core professional competence that I would expect every doctor to not only be taught but to receive feedback on and review. And the adage that our handwriting can be quite poor is no excuse to maintaining clear, dated, signed records that are easy to see by others and we emphasise that throughout the training journey.

THE CHAIR: Where does that feedback come from, if you don't mind my asking?

A. So particularly for resident doctors in training, that will come from their clinical supervisor or supervising clinician or from other colleagues that they work with. And I don't want to say something is very poor practice, but the notes that we keep, we have a duty that they are legible, easy to read, making clear descriptions of our assessment of the patient and our diagnosis, treatment plan, and that they are timed, dated and signed. And that is something that we do teach our resident doctors, both from undergraduate all the way through.

MR DAWSON: Thank you for that. One other aspect that may have some significance in our Inquiry is the extent to which people who arrive at the beginning of the process that you've described -- and you talked about maybe a sort of classical journey of being educated within the United Kingdom, getting the MBChB and moving to later stages -- and you did, I think, mention people going out or back in and gaining -- people coming in at different levels of experience.

One aspect of which is of interest to us that I would be interested to understand from you is the extent to which people who have acquired medical qualifications in other places, other countries, other systems, how the medical education that's delivered now seeks to assist those resident doctors. So, for

example, if they've done their undergraduate degree somewhere else or they've perhaps done a certain element of training somewhere else and wished to join the training system here, is that something that your organisation is involved in to some extent? And what steps can be taken to do that? Because it is, I think, from the sophisticated systems that exist, very important that certain standards are met such that someone progresses as appropriate through the system and fitting in conceptions of things that have arisen from other areas maybe make that more difficult.

I'm interested in your reflections on that.

A. So for resident doctors in training, we do recruit some resident doctors in training from overseas. Not all overseas medical degrees are recognised by the GMC, so the GMC have certain standards that they hold overseas medical schools to, to be able to say the doctor is eligible to be registered by the GMC in the UK. So that's one of the first safeguards.

The second safeguard is that we, when recruiting doctors from overseas, ask for evidence of where they are in their training journey and that they have that signed off by a supervisor who has a recognised qualification and a certain standing.

The next element would be how we support resident

doctors in training who come to the UK from overseas. So we have programmes of lengthy induction where their clinical practice can be supervised so that we can ensure they are at the standard that we expect. And for the majority they are but for a very small minority they are not and at that point we intervene with educational interventions, perhaps placing them in a different environment and supporting them to learn the skills that they need to deliver safe patient care.

Q. On the first part of that -- so the support part you've mentioned there, but the first part which is to get some sort of indication as to what level in the training journey they reached and some sort of certification from a medical professional, their supervisor or you said of a certain standing, is that a process that you're doing or is it the GMC, or are you just trying to work out where they fit into the journey here?

A. So medical recruitment for resident doctors in training is delivered for the UK by NHS England and they've got specific systems in play to support the gathering of that information and the checking and we can provide further detail of that to the Inquiry if it's helpful.

Q. That would be very interesting to us, thank you for that. I have a few more questions for you on the subject of some helpful evidence you have been able to

provide, no doubt looking in the archives, about Mr Eljamel himself. I wonder if we can go back to the statement, please. Paragraph 13.1. We'll read this out in a second but this is a context in which we're asking questions about whether you have -- you can give us a broad chronology of the involvement of NHS Education for Scotland or the predecessor body with Mr Eljamel and I'm aware you've conducted a search and we talked about the searches earlier and the assumptions made about the record retention policy. But one thing that comes up in this paragraph is that because of the role that he was playing, it's a safe assumption, isn't it, even if there's no record, that Mr Eljamel was a clinical and/or educational supervisor as he was a consultant and there were very few consultants in the unit?

A. Yes, that would be right.

Q. Yes, thank you. So just to give some context. What you tell us here:

"NES have no knowledge of NES or its predecessor bodies being involved with, or aware of, the professional practice of Mr Eljamel. To the best of our knowledge, Mr Eljamel would have held Supervisor roles and would have needed to complete the required training. Due to our record retention policy ... we no longer hold any documentation in relation to any training undertaken

by Mr Eljamel. We know he stepped down in July 2012 but cannot confirm when he commenced these roles.

And then just moving forward to a later paragraph you tell us, in paragraph 20.5, please:

"Mr Eljamel served as an approved Educational and Clinical Supervisor for Resident Doctors in Training with NHS Tayside until July 2012. Accordingly, it was expected that NHS Tayside would verify his competency for this position and promptly escalate any concerns to NES should they arise. No concerns were ever raised with NES. NES do not hold any documentation in relation to this appointment as the appointment would have been made by Mr Eljamel's employer.

"Mr Eljamel stopped being a Supervisor in 2012. NES are not aware if this was due to suspension or not. As explained above, NES do not assign the supervisors to the RDiT [resident doctors in training] as this is managed by the Health Board.

"It would be inappropriate for a suspended doctor to continue in any capacity as a clinical or educational supervisor."

Now, just to work this out. So you have helpfully deduced, in the first instance, that he must have been, because of the role he had, an educational, probably and clinical supervisor, not necessarily to the same person,

as we've discussed; is that right?

A. That is my understanding.

Q. And you've also told us that he stopped being an educational and clinical supervisor for resident doctors in training in July 2012, is that right?

A. That is my understanding.

Q. How do you know that?

A. So -- and I have asked my team to clarify this for me. We have a record of who are the educational and clinical supervisors and he stopped being on that record in July 2012.

Q. Okay, because you speculate -- helpfully, I don't mean to be critical -- that this may be connected with his suspension, but that happened later than that. So the July 2012 date derives from your records but does he just not appear on it again, is that what happens?

A. That's right, he's removed from the record as an educational supervisor.

Q. So, you do still have a record of that, but you did you manage to find any records as to why that might have happened at that time?

A. No, unfortunately not.

Q. But would he have had to -- what would the system have been for him to have appeared on that, would he have had to have been reregistered every year, or ...?

A. So my understanding is that the directors of medical education in the health board upload the list of educational and clinical supervisors to our data base. Doctors appear and come off that database and it would be unusual for us to have a reason given for that. It could be that they have taken on another role and don't have the capacity or time in the job plan to do the role. It could be a matter that's been decided in the clinical department that that person is not to continue in that role.

Q. I see. I don't know whether we've seen that record but we would like to see it. I'm sure it will contain names of other people but obviously we have systems to make sure that their names which are not relevant for our purposes wouldn't be displayed or anything like that. So that would be very useful to see.

THE CHAIR: Sorry, Professor, can I just double-check with you who it was you said would be responsible, or at least you would expect to upload to your database? Did I understand you to say the director of education?

A. The director of medical education.

THE CHAIR: Medical education in the health board.

A. Yes.

THE CHAIR: Thank you.

MR DAWSON: Is that part of the department of medical

education, or is that something different?

A. So each health board has a medical education structure that has a director of medical education who works to the medical director to ensure that there are standards supporting the delivery of medical education in that board, including the appointment of educational and clinical supervisors, but also ensuring that the resident doctors in training have the right induction, the right access to learning environments, have their educational needs met and they're a really important part of that educational and governance system in the boards.

Q. Okay. That's someone I assume that your organisation would liaise with frequently?

A. Yes.

THE CHAIR: Sorry, that's a medical practitioner?

A. It's a medical practitioner.

MR DAWSON: Just going back to the previous page, please, paragraph 20.1. You say there -- again, this is under "conclusions" section:

"To the best of our knowledge, NES and its predecessor bodies were not informed of any concerns or challenges regarding Mr Eljamel's professional conduct from Resident Doctors in Training, Educators, NHS staff, or NHS Tayside. Established protocols existed at the

time for reporting such matters, and NES would have responded appropriately had any issues been brought to its attention."

So just on, first of all, the first part about no reports having been made, that you repeat several times is based on the documentation that you've been able to access?

A. That's correct.

Q. It's possible, of course, and you've helpfully provided us with the identity of some individuals who might have been around near the time that could help us with that, but that's just based on that assessment?

A. That's right.

Q. And the part at the end when you say "NES would have responded appropriately", is an assumption on your part?

A. Umm, so, it's an assumption but based on a knowledge of how NHS Education for Scotland did have systems and processes in place where they did undertake visits and reviews when concerns were raised with them.

Q. But I'm just trying to clarify that you don't have any evidence of the first part and you don't have any evidence of the second part either. You're assuming it based on your knowledge of the systems?

A. Yes, I don't have any documented evidence.

Q. Thank you. And in paragraph 20.2, it says:

"In 2009, Health Boards in Scotland were contacted by NHS Education for Scotland (NES) to identify Consultants capable of facilitating local Educational Supervisor courses provided by NES. NHS Tayside recommended Mr Eljamel as a facilitator to run the course. Subsequently, he served as a facilitator for this course during the period 2009-2010. Unfortunately, due to the NES retention policy ... there is no documentation available in relation to this. It would have been our expectation that NHS Tayside had no reservations regarding his role in delivering this course and would have escalated any concerns to us if they had arisen. No concerns were ever raised regarding the delivery of these courses by Mr Eljamel and others."

Again, similar to the other part, how is it that you know that NHS Tayside recommended Mr Eljamel and how is it you know that he served as the facilitator over that year?

A. So in terms of knowing it was NHS Tayside who recommended Mr Eljamel, that that will be based on -- that is the board that he was working in and the NHS Education for Scotland went to individual boards to provide local faculty to deliver that course. So I don't believe I have any written or documented evidence for that, but --

Q. That might be a safe assumption then?

A. But it might be a safe assumption.

Q. Right, but as to how he actually held that post for that year?

A. So we have got -- so, I have been informed by my team that they have got evidence that he was a facilitator on the Scots course between 2009 and 2010.

Q. Again, it would be useful to see that. It may be something similar to the log or whatever register we saw earlier, but that would be helpful. Just in terms of what that is, I'm assuming that that is -- because of the educational supervisor is appointed locally, they would run courses to be able to make sure that people are able to perform the function properly, but I think did you not tell us earlier that NHS Education for Scotland also provides courses for the supervisors and that was their limited function with them?

A. So at the time, the Scots courses were written by colleagues working within NHS Education for Scotland and some were delivered by educational faculty from NHS Education for Scotland. There were some local delivery of courses that were either done in collaboration with colleagues from NHS Education for Scotland or by faculty from within the health boards but to the educational product that was developed by NHS Education for

Scotland.

Q. So just the use of the word "facilitator", I suppose I'm trying to work out, is that someone who liaises with NHS Education for Scotland or actually delivers the course, or --

A. So my understanding of that term is that the facilitator would have been an active participant in delivering the course. They wouldn't have been the sole deliverer.

Q. And as I understand the role of educational supervisor, that would be potentially across, is that the whole hospital or the whole board? Because there would be educational supervisors required in every department?

A. Yes. So it would be around the generic skills that you would expect the educational supervisor or clinical supervisor to have and what evidence they would be looking for. I can't speak to the technical aspects of the Scots course.

Q. Right. Do you think -- well, I know a lot of the documentation doesn't exist, but are there documents, do you think, that would tell us what the Scots course -- or some more detail about that? It's the Scots course we're talking about, I assume?

A. Yes, we can find out if we still have examples of that.

Q. Yes, it would be very helpful to know. In particular the sorts of people who might have been receiving that

training, that would be very useful to know. Those are all the questions that I have for you. Thank you.

THE CHAIR: I have one point, Mr Dawson. On this -- and again, the absence of documentation may mean that you can't answer or can't answer specifically in relation to Mr Eljamel -- but I note from paragraph 20.2, that this proceeded, or appears to have proceeded, on a recommendation of the relevant health board. Is that a recommendation that would, as a matter of course, be checked or would it simply be accepted?

A. I wasn't working with NHS Education for Scotland then and I don't know what their processes would have been, I'm sorry.

THE CHAIR: All right, thank you.

MR DAWSON: Would it be now?

A. So now, in terms of recruiting faculty to deliver, I would need to go back and check what our protocols are.

Q. We would be very much obliged if you do so. Those are all the questions I have with you. What happens now is we have a very short break where we ask our core participants if they have any further questions. So, thank you.

THE CHAIR: Do you want to ask the witness if she has anything that she wants to add?

MR DAWSON: Yes, sorry. I usually, at this stage, ask witnesses whether there is anything they'd like to add, so I'd ask you that?

A. Would that be okay?

Q. Yes, absolutely. Of course, please.

A. So I would like to make a reflection and it's particularly about an area that you highlighted earlier in that interplay between educational and clinical governance. And much of my evidence this afternoon has been about educational governance and the role of NHS Education for Scotland. And one of my reflections is that educational governance should not be viewed solely as a mechanism for assessing resident doctor in training safety and training quality. I think it forms an important part of the wider patient safety architecture.

Resident doctors in training work at the front line of care every day, they experience supervision, culture, workload, behaviours and the realities of clinical practice and they can provide an important early warning signal about risks in the system.

Educational and clinical governance have different responsibilities but they are looking at the same clinical environment through a different lens.

One of the lessons for me, in reviewing the

materials for this Inquiry, is the importance of ensuring information relevant to patient safety, doctor and training safety, professional practice, is recognised, acted on, but importantly, connected.

The system today is more formalised and better connected but improvement is a continuous process and I think there might be real value in strengthening the integration between clinical and educational governance to support earlier recognition to achieve an even safer connected system for our patients. Thank you.

MR DAWSON: Thank you.

THE CHAIR: Thank you. Anything you want to follow up on?

MR DAWSON: Nothing to follow up, sir.

THE CHAIR: All right, we'll take a short break while we check whether there are any remaining questions, so if I can ask you to go with Ms Miller back to the witness room we'll resume again shortly. Thank you.

(4.19 pm)

(A short break)

(4.26 pm)

THE CHAIR: Thank you. Mr Dawson.

MR DAWSON: Thank you, sir. There are, in fact, no further questions from the core participants. Thank you very much.

THE CHAIR: Thank you very much. Professor, thank you very

much. You will just have gathered that that brings your evidence to an end. And just before you go, can I extend the Inquiry's thanks, and indeed my personal thanks, for you attending the hearing suite today to give evidence and indeed for the work that's obviously gone into preparing this statement and associated materials. It's much appreciated. As is also your kind offer to submit any further materials. If there's any dubiety about what we were looking for, no doubt that can be dealt with in correspondence. But with those thanks having been extended, you're free to go.

A. Thank you so much.

MR DAWSON: No further witnesses for today, sir.

THE CHAIR: All right, thank you.

(4.27 pm)

(The hearing adjourned until 10.00 am on Friday, 11 September 2026)

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