

1 Thursday, 1 October 2026 2 (10.00 am) 3 (Proceedings delayed) 4 (10.11 am) 5 THE CHAIR: Good morning. 6 MR DAWSON: Good morning, sir. Today we are hearing the 7 first instalment of the evidence from our healthcare 8 administration group. 9 THE CHAIR: Yes, thank you. 10 Good morning to each of you and thank you for your 11 attendance this morning at the hearing suite. We're 12 about to start the first session of your evidence but 13 before we do that, there are certain formalities that 14 I must go through and that requires me to administer the 15 affirmation to each of you individually. So if I can 16 start, Professor Walshe, with you. 17 PROFESSOR KIERAN WALSH (affirmed) 18 PROFESSOR ANNE-MAREE FARRELL (affirmed) 19 DR FAY GILDER (affirmed) 20 Questions by COUNSEL TO THE INQUIRY 21 MR DAWSON: Thank you, sir. 22 Good morning. I'm just going to go across from left 23 to right here. You are Professor Kieran Walshe; is that 24 correct? 25 A. Yes. Page 1	1 right? 2 A. That's correct. 3 Q. Could we have a look, please, at ELJ0003-00172. Is that 4 the first page of your report? 5 A. That is correct. 6 Q. And your report is dated 7 August 2026; is that correct? 7 A. Correct. 8 Q. Could we go to page 121, please. Just scroll down 9 a little bit. Although this is blanked out for data 10 protection purposes, does your signature appear there 11 where it says your name in the original version, 12 Professor Farrell? 13 A. Correct. 14 Q. And Dr Gilder, does your signature appear where your 15 name is? 16 DR GILDER: Yes, it does. 17 MR DAWSON: Professor Walshe, does your name appear at the 18 bottom? 19 PROFESSOR WALSH: It does. 20 Q. Thank you. If we scroll back to the top of that page, 21 please, 121. You say there: 22 "We confirm we have made clear which facts and 23 matters referred to in this report are within our own 24 knowledge and which are not. Those that are within our 25 knowledge we confirm to be true. Page 3
1 Q. You are Professor Anne-Maree Farrell; is that correct? 2 A. That's correct, yes. 3 Q. And you are Dr Fay Gilder, is that right? 4 A. That's correct. 5 Q. I wonder if, for this section, if I could direct 6 questions to Professor Farrell as I understand, 7 Professor Farrell, that you took on the leadership of 8 this group; is that correct? 9 PROFESSOR FARRELL: That is correct. 10 Q. I will say that I have indicated to all of you, but for 11 this section and any other section, if there are matters 12 on which you'd like to contribute, I will principally 13 direct my questions to the person whom I understand 14 prepared a first draft of the answer to those questions, 15 but please feel free to contribute at any stage and 16 indeed, to nominate any others if you feel that they 17 would be able to contribute on any particular question. 18 Professor Farrell, I understand that you received 19 a letter of instruction to act as the lead of this 20 Inquiry's healthcare administration group; is that 21 correct? 22 PROFESSOR FARRELL: That's correct. 23 Q. And that your colleagues also received letters of 24 instruction which were in the same terms although 25 directed to them not as lead of the group, is that Page 2	1 "We understand our duty to provide independent 2 evidence and have complied with that duty in the 3 provision of this report. The opinions we've expressed 4 represent our true and complete professional opinions on 5 the matters to which they refer." 6 Is that an accurate statement, Professor Farrell? 7 PROFESSOR FARRELL: Yes, it is, correct. 8 Q. Is that an accurate statement, Professor Walshe? 9 PROFESSOR WALSH: Yes. 10 Q. And is that accurate, Dr Gilder? 11 DR GILDER: Yes, it is. 12 Q. Thank you. I'm going to ask you some questions now 13 about each of your backgrounds and your expertise to 14 provide the evidence that you have, starting again, with 15 Professor Farrell. You are a professor of medical 16 jurisprudence at the University of Edinburgh, is that 17 correct? 18 A. That's correct. 19 Q. And indeed, you are the director of the Mason Institute at 20 Edinburgh University, is that correct? 21 A. That's correct. 22 Q. You are a lawyer by training? 23 A. I am indeed, yes. 24 Q. And in terms of your areas of research and policy 25 expertise, you helpfully provided a CV to the Inquiry. Page 4

1 You have told us that one of your interests is in the 2 area of policy. Could you tell us what that is? 3 A. Around health policy? 4 Q. Health policy. 5 A. So a lot of my research has been focused on health 6 policy, administration and regulation arising in health 7 systems, with particular reference to this report. 8 Q. Thank you. And you have an interest, I think, in the 9 field of medical law, medical ethics and healthcare 10 administration broadly? 11 A. That's correct. So I have broad backgrounds in both 12 public policy and law as well and the politics of health 13 systems. 14 Q. Thank you very much. I understand that you hold 15 a Bachelor of Laws and Bachelor of Arts degree from the 16 University of Melbourne? 17 A. That's correct. 18 Q. A Bachelor of Letters from the University of Melbourne? 19 A. Unique to Melbourne, but, yes. 20 Q. Okay, A Master of Arts and Politics from University 21 College Dublin? 22 A. That's correct. 23 Q. And a Doctor of Philosophy, I think in government, from 24 the University of Manchester; is that right? 25 A. That's correct, yes. Page 5	1 certainly -- 2 A. Yes. 3 Q. -- but also contains a certain amount beyond medical 4 ethics in terms of the legal landscape in which 5 healthcare is delivered in Scotland; is that correct? 6 A. That's correct. It is, I think, the only textbook that 7 does cover or adopt a UK wide approach to examining 8 health systems, policy and ethics and law on a UK-wide 9 basis, including Scotland. 10 Q. Thank you. We'll come on to some aspects of that in 11 connection with which you've helpfully provided us 12 evidence in due course. 13 If I can move on to Dr Gilder, you also have 14 helpfully provided us with a curriculum vitae which sets 15 out for us that you're a consultant anaesthetist by 16 training, I think? 17 A. I am. 18 Q. I understand from your CV that you became a fellow of 19 the Royal College of Anaesthetists in 1995? 20 A. By examination, yes. 21 Q. And that you received an accolade from the Institute of 22 Leadership and Management called a level 7 in executive 23 coaching in 2020; is that correct? 24 A. That is correct. 25 Q. And that you received something called an EQI Page 7
1 Q. And that you have, in the past, worked in various 2 different universities before arriving in your current 3 position in Edinburgh, is that right? 4 A. That's correct. 5 Q. What other universities have you worked in and broadly 6 what posts did you hold? 7 A. Okay. In the UK, I have worked at Lancaster University 8 as a lecturer and at Manchester as a lecturer and senior 9 lecturer. I worked at Monash University in Melbourne, 10 Australia as an associate professor and the La Trobe 11 University as a professor, then at Queen's University as 12 a professor and now at Edinburgh. 13 Q. Thank you, and before that, I understand you worked as 14 a lawyer in private practice? 15 A. Yes, I was a partner in a law firm known as 16 Slater & Gordon and I worked specialising in 17 health-related litigation on behalf of patients and 18 families in Australia and Ireland and also in 19 North America. 20 Q. Thank you very much. Am I correct in thinking that 21 you're the current editor of the "Law and Medical 22 Ethics" book that was originally written by Mason and 23 McCall Smith? 24 A. That's correct, yes. 25 Q. That's a book which is familiar to law students, Page 6	1 practitioner qualification in 2023; what's that? 2 A. So emotional intelligence. So I'm very interested in 3 leadership in the context of organisations under 4 considerable pressure and stress, which I'm sure most of 5 you would understand the National Health Service has 6 plenty of, and in the role that I most recently had 7 which was a medical director we are working -- we are 8 leaders, role model leadership and we need to work 9 with our workforce, if you like, to help them deliver 10 care in the best possible way under considerable duress. 11 And things like understanding sort of coaching 12 techniques, emotional intelligence, supports both my 13 ability to work with people under stress and my ability 14 to work with myself under stress. So it's quite 15 a useful qualification and understanding to have in 16 terms of your personal development as a leader. 17 Q. Understood, thank you very much. I understand you 18 worked as a consultant anaesthetist within Cambridge 19 University Hospitals Trust between 2003 and 2020? 20 A. I did. 21 Q. Where was that based? What hospital was that based? 22 A. That's Cambridge University Hospital Foundation Trust, 23 so it's a big teaching hospital based in Cambridge and 24 it represents most sub-specialties of medicine. 25 Q. Thank you. And you were the specialty lead, I think, in Page 8

1 pre-operative assessment between 2010 and 2016? 2 A. I was. 3 Q. You were the specialty lead for perioperative medicine 4 between 2016 and 2018? 5 A. Yes, and that's just an extension how we work up 6 patients and how we think about how we look after them 7 post-operatively in a slightly more holistic way. 8 Q. Thank you, so that would mean both pre- and post -- 9 A. (Overspeaking) Yes, exactly, so it sort of encompassed 10 my pre-operative assessment role, but it focused a lot 11 more on how we ensure better outcomes for patients in 12 terms of the way we prepare them for surgery but also 13 the way we prepare them for post-operative recovery as 14 well. 15 Q. And so do these lead roles involve you supervising or 16 training others in the skills that were required in 17 those areas? 18 A. Yes, because we ran clinics, so we had trainee doctors 19 in clinics. We also had a multi-disciplinary trainee, 20 so I supervised pharmacists, nurses, occupational 21 therapists, physiotherapists in those environments as 22 well. 23 Q. And I understand as part of that trust you were also the 24 clinical director for improvement and transformation 25 between 2018 and 2020, is that right? Page 9	1 Q. Right, thank you very much. I understand that during 2 the period in which you were medical director of that 3 particular trust, the trust was going through a number 4 of difficulties and transitions, is that right? 5 A. It was significant. 6 Q. Can you tell us broadly what sorts of things you had to 7 cope with over that difficult period? 8 A. Yes. So one of the very first things that I had to 9 focus on was Covid. We entered the second wave of Covid 10 just after I started. So the organisation is in the 11 London penumbra, and London was hit very badly by Covid 12 and Harlow was as well, so we had a disproportionate 13 amount of Covid patients. So, from that perspective, 14 I oversaw the clinical emergency response to Covid at 15 the time to how we looked after incredibly sick patients 16 in a very restricted environment. So that was the 17 immediate -- literally three days after I walked through 18 the door, that was the immediate focus. 19 The more strategic element of it is that our 20 mortality indices were amongst the worst in the east of 21 England. What that means, to those of you who don't 22 quite know, is that if you came to our hospital with 23 a condition, a diagnosis, you might not have such a good 24 outcome as if you went to another hospital in the 25 region, in the context of death being an outcome. Page 11
1 A. Yes, that was a deputy executive role, it was half-time. 2 The purpose of that role was to work with Cambridge to 3 support the organisation and become 4 an improvement-focused organisation and to bring on 5 an organisation which Scotland knows very well which is 6 the Institute for Healthcare Improvement to support 7 Cambridge in that time in their improvement journey. 8 Q. Thank you. I understand more recently you were the 9 medical director at the Princess Alexandra Hospital NHS 10 Trust, is that right? 11 A. I was. 12 Q. Between November 2020 and August 2025? 13 A. Correct. 14 Q. And that in that role, you also held the 15 responsibilities over that period as the responsible 16 officer -- 17 A. I did. 18 Q. -- about which we've heard some evidence already. 19 A. Yes. 20 Q. And also as something else called a Caldicott guardian? 21 A. I was the Caldicott guardian. 22 Q. Could you tell us what the Caldicott guardian means? 23 A. The Caldicott guardian is the individual that holds the 24 organisation to account and assures good practice when 25 it comes to confidentiality of patient records. Page 10	1 However, we did a huge amount of work and there are 2 three sort of areas where you think morbidity. One is 3 obviously the care of the patient, which is fundamental 4 but other important areas are clinical documentation and 5 recording of care, coding of care. So we obviously 6 focused on our care pathways first of all, but there was 7 actually quite a lot of data improvement to do. And yes, 8 we became one of the best in the east of England within 9 three years and we held that position. 10 Q. Right. Why is data improvement, as you've called it, 11 particularly important in relation to securing better 12 outcomes for patients? 13 A. Well, it's not. This is a numbers exercise, if 14 I'm absolutely honest. The standardised mortality 15 ratio, which is the index I'm talking about, and the 16 HSMR, the hospital standardised mortality ratio. Both 17 of those are dependent on complex statistical 18 algorithms, based on the coding of the data that we send 19 in. 20 So, for example, we had a lot of patients who would 21 come as end of life patients and clearly their life 22 expectancy is going to be lower and you would expect 23 a higher mortality rate. So they are more likely to die 24 in hospital than someone who is not at end of life. And 25 we were not coding for end of life and that affects the Page 12

3 (Pages 9 to 12)

1 statistical outcome. So it's data like that. So it's 2 not fiddling the numbers it's recording your care 3 accurately and we weren't doing that particularly well. 4 Q. Thank you, and as far as your current roles are 5 concerned I understand that you hold an honorary 6 fellowship at the Cambridge University Judge Business 7 School; is that correct? 8 A. I do. 9 Q. And the title that I've seen written down is the 10 "director of healthcare concentration", is that -- 11 A. (Overspeaking) Haha. Yes, so the Cambridge Judge 12 Business School has an MBA programme and within that, it 13 offers specialist concentrations to our MBA students, 14 one of which is healthcare and I oversee the healthcare 15 element of that. 16 Q. Understood, and I think you also hold another role with 17 Deloitte, is that correct? 18 A. I do. So I'm an associate with Deloitte which means 19 I'm a contractor and the work that I'm doing with them 20 is with the new hospital programme. This is a national 21 infrastructure programme that will build 46 hospitals in 22 about the next 20 years and it's my role is to work on 23 something called "occupant safety", which is -- the purpose of 24 which 25 is how do we ensure, through the entire process, the 25 life cycle of from design to operation to maintaining Page 13	1 Q. Thank you. You provided us with a long list of 2 different roles that you've held, one in particular 3 I was going to ask you about was I understand between 4 2012 and 2015 you were associate director of the 5 National Institute for Health Research, health services 6 and delivery research programme; is that correct? 7 A. Yes. 8 Q. Could you tell us what that involved? 9 A. So that was the first of a couple of secondments I have 10 done where I've worked in national R&D programmes to, if 11 you like, sit on the other side of the fence from my 12 role as a researcher. I have been a research 13 commissioner, so helping to oversee, design the 14 strategies for research commissioning, choose the 15 research topics, then oversee the processes within the 16 National Institute for Health Research, which is the 17 main government research fund of health research in 18 England, to oversee then the administration, the 19 secretariat and the processes for getting that research 20 done and then seeing its results disseminated and used. 21 Q. I understand that you also held the role as a director 22 of the Health and Care Research Wales which is 23 an organisation in Welsh Government; is that correct? 24 A. Yes. So Health and Care Research Wales is part of Welsh 25 Government. It is the equivalent of the National Institute Page 15
1 the hospital, how do we ensure that the focus of -- that 2 our focus is the safety of our occupants of the 3 hospital. And "occupants" doesn't just mean patients, 4 it means staff, it means visitors, it means contractors. 5 So anyone who comes into this new building. 6 Q. Thank you very much. Professor Walshe, you have also 7 helpfully provided with us a CV, giving details of your 8 background, but you are currently professor of health 9 policy and management at the University of Manchester, 10 is that correct? 11 PROFESSOR WALSH: That's right. 12 Q. As far as qualifications are concerned, you hold a BSc 13 (Honours) in computer science from the University of 14 Manchester; is that correct? 15 A. Yes. 16 Q. And you hold a PhD from the University of Birmingham on 17 measures of quality and healthcare, is that right? 18 A. Yes. 19 Q. Could you tell us a little bit more about the PhD and what it 20 was 21 about? 22 A. It's quite a long time ago but my PhD was looking at the 23 use of measures of quality that rely on identifying, 24 tracking and monitoring adverse occurrences in 25 healthcare and using those adverse occurrences as 25 opportunities for learning. Page 14	1 for Health Research in England, although with 2 a considerably smaller budget, and it oversees and 3 commissions health research in Wales. It also acts on 4 behalf of Wales in UK-wide programmes of research and in 5 liaison with UK-wide funders such as the medical 6 research counsel and UKRI. 7 Q. Thank you. I understand that your research has had 8 a number of focuses but those include quality and 9 performance in healthcare organisations, is that right? 10 A. Yes, I think that's probably been the predominant theme 11 in my research really for the last 25 years. 12 Q. It also covers the regulation, governance, 13 accountability and performance of public services? 14 A. Yes, I have done a lot of research on organisational 15 regulation, the role of organisations like the Care 16 Quality Commission in England but also on professional 17 regulation, predominantly on the role of the General 18 Medical Council. 19 Q. And I think you have also published and undertaken 20 research in the area of the use of evidence in policy 21 evaluation and learning? 22 A. Yes, evidence-based decision-making. 23 Q. Thank you. And your current research, as I understand 24 it, includes organisational and professional regulation 25 to which you referred, I think? Page 16

1 A. Yes. 2 Q. It also includes the healthcare workforce, is that 3 right? 4 A. Yes. 5 Q. And quality and safety at the interface between the NHS 6 and the independent health sector, is that right? 7 A. Yes. 8 Q. I understand that you are the author or editor of six 9 books, is that right? 10 A. Yes. 11 Q. And I don't know if this is out of date, you are the 12 author or co-author of around 160 papers in academic 13 peer-review journals, is that right? 14 A. Something like that, yes. 15 Q. Thank you. I understand also that you have an interest 16 in the work of healthcare-related public inquiries? 17 A. Indeed. 18 Q. Could I just -- again, I'll now go back to 19 Professor Farrell to ask some more questions about the 20 instruction, but again, for Professor Walshe and 21 Dr Gilder, if there are any aspects on this you feel 22 that you'd like to contribute, then please feel free to 23 do so. 24 As I've said already, you were sent separate letters 25 of instruction, is that correct? Page 17	1 matters which fall within your expertise only? 2 A. Yes, that's correct. 3 Q. And that you were required to provide opinions on 4 matters falling within your expertise and if there were 5 matters about which you had been asked which did not, or 6 do not including today, that you would require to 7 indicate that the question fell beyond your expertise? 8 A. Yes, and we noted that in the report. 9 Q. Thank you. Did the group understand that you were 10 required to give details of any literature or other 11 material upon which you relied in the compilation of 12 your report? 13 A. Yes, that is correct. 14 Q. And you did so? 15 A. We did. 16 Q. Thank you. And you were also required, did you 17 understand, to indicate, in circumstances where there 18 was a range of professional opinion on any matter, that 19 you were required to summarise the range of those 20 opinions and give reason for any opinion or opinions 21 reached by you? 22 A. That's correct. 23 Q. You were also required to provide a summary of your 24 conclusions in your report? 25 A. That's correct. Page 19
1 PROFESSOR FARRELL: That's correct. 2 Q. Although the terms of the letters and the questions you 3 were asked and the basis upon which you were instructed 4 was the same, other than the fact that you were the lead 5 of the group, Professor Farrell, is that right? 6 A. That's correct, yes. 7 Q. In compiling the report in accordance with your 8 instruction, did the group understand that you were 9 required to provide your report as independent experts? 10 A. Yes, that's correct. 11 Q. And that you were required to provide your unbiased 12 opinions on the matters which were addressed to you in 13 the letters of instruction? 14 A. That's correct. 15 Q. That your overriding duty was and is to assist the Chair 16 of the Inquiry on matters within your expertise? 17 A. Yes. 18 Q. That, as experts, you had and have a duty to exercise 19 reasonable skill and care in carrying out your 20 instruction and that you required and require to comply 21 with any relevant professional code of practice? 22 A. Yes, that's correct. 23 Q. Did the group understand that your overriding duty is to 24 assist the Inquiry and, as I've said, to provide your 25 unbiased opinion as independent experts in relation to Page 18	1 Q. Thank you. And also, in circumstances where you were 2 not able to give an opinion without qualification, that 3 you were required to state that as well as any 4 qualification to any opinion you expressed? 5 A. That's correct. 6 Q. And, as you've told us already, I think the opinions 7 you've expressed represent your true and complete 8 professional opinions on the matters to which they 9 refer, is that right? 10 A. That's correct. 11 Q. Also you required to indicate where, amongst you, there 12 were any different opinions, did you understand that? 13 A. Yes, we did. 14 Q. And were there areas in which you differed on certain 15 matters or did you find that your opinions concurred? 16 A. We have complementary expertise and we worked together 17 and we reviewed our drafts and the research that we did 18 in order to reach a consensus and agreed position. 19 Q. Thank you very much. And it was also the position, did 20 you understand, that in providing your report, and 21 indeed your evidence to the Inquiry today, that you 22 required to have no conflict of interest which would 23 undermine the independence of your evidence in 24 connection with the work of the Inquiry, in particular 25 that you have no relevant connection or interest Page 20

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1 connected to NHS Tayside, the Scottish Executive or 2 government, Mr Sam Eljamel, Fernbrae Hospital, Circle 3 Healthcare or any other body named in the Inquiry's 4 Terms of Reference? 5 A. For myself, that is correct. I do work with some 6 Scottish Government advisory committees but that's the 7 extent of it. Perhaps you'd like to address -- 8 Q. Yes, was that your understanding of the basis of your 9 instruction, Dr Gilder? 10 DR GILDER: Yes, no conflict of interest. 11 Q. Thank you, and Professor Walshe? 12 PROFESSOR WALSH: Absolutely, yes. 13 Q. Thank you. I think you might be referring -- in your 14 CV, I think you mentioned for a very period you had some 15 work with Healthcare Improvement Scotland, is that 16 right, Professor Farrell? 17 PROFESSOR FARRELL: That's correct, and I have done for the 18 expert advisory groups for the Scottish Government, 19 mainly in relation to abortion law reform and health 20 misinformation. 21 Q. Yes, and I think you were involved in providing a report 22 to the Scottish Covid Inquiry as well, which -- 23 A. (Overspeaking) Yes, sorry. That was commissioned as 24 well, yes -- 25 Q. Yes, you set -- Page 21	1 period since then -- 2 A. And even before actually, to note the evolution of 3 thinking and policy making and law making because often 4 it's not a single moment in time, as I'm sure you'll 5 appreciate. So you'll see in the report we have set 6 background context prior to the start of the relevant 7 period and then beyond that, where we thought it was 8 relevant and appropriate. 9 Q. Thank you, that's very helpful. And another aspect of 10 the instruction which I ask you to indicate that you 11 understand is that you weren't asked, at this stage, to 12 consider any specific matters relating to Mr Eljamel or 13 his practice or the systems around that practice, was 14 that your understanding? 15 A. That was certainly my understanding. I would defer to 16 my colleagues, but, yes, we did discuss that and we have 17 addressed matters as set out in the letter of 18 instruction. 19 Q. Thank you and the letter of instruction asked you to 20 provide broad opinions on matters of principle of 21 relevance to this Inquiry, is that right? 22 A. That's correct. 23 Q. And indeed, you understand that it may be the Inquiry's 24 intention in due course to seek further evidence from 25 you, including the possibility that we may wish to ask Page 23
1 A. The first iteration of the Inquiry. 2 Q. Thank you very much. You've set all that out in your 3 CV? 4 A. I did, yes. 5 Q. And I think, from what you've told me, you didn't 6 consider that that constituted any conflict of interest you 7 were being asked to address on this by this Inquiry? 8 A. No, it did not. 9 Q. Thank you very much indeed. One other aspect that will 10 come up during the course of the evidence today is that 11 you were -- in your letters of instruction we defined 12 something that we called the "relevant period" which was 13 the period from 9 October 1995 to 2015. We did so in 14 order to try to focus your answers as best you could on 15 that being the main period in which this Inquiry is 16 interested because it's the period which covers 17 Mr Eljamel's appointment as a consultant neurosurgeon in 18 Tayside, to the point when his name was removed 19 voluntarily from the medical register. Did you 20 understand that's what we were interested in primarily? 21 A. Yes, so in the report you'll note us saying "during the 22 relevant period" and we took that to mean that period 23 you've just noted. 24 Q. Excellent, but we did also ask you to provide evidence 25 of matters insofar as you thought them relevant in the Page 22	1 you questions about particular matters that arise from 2 the factual evidence that we gather in the months 3 and years to come? 4 A. Yes, we do understand that. 5 Q. Thank you. Very helpful. As far as the compilation of 6 the report is concerned, I wonder if -- you've set some 7 details out in the report about how you went about doing 8 it. I wonder if you could tell us, Professor Farrell, 9 broadly how it was that you allocated responsibilities 10 amongst yourselves as to how you would finalise the 11 report you were asked to prepare? 12 A. Yes. The three of us met on a regular basis to discuss 13 the evolution of the writing of the report and the 14 research that needed to be done. So that was done, as 15 I said, on a regular basis over a number of months. 16 Then various matters were assigned to each of us 17 individually. I took responsibility for drafting the 18 full report based on that input and we all reviewed that 19 draft before coming to a final draft or version that was 20 presented to you. 21 Q. Thank you very much. And so would it be fair to say 22 that, at the end of the day, the report constitutes the 23 report of the group? 24 A. That is correct. 25 Q. Thank you, that's helpful. There are a couple of Page 24

1 concepts I'd just like to discuss with you at the 2 beginning about the way in which you were asked to 3 compile the report and some ideas that went into the way 4 in which you were instructed but also the way in which 5 you carried out the exercise. I might, at this stage, 6 start with Dr Gilder, in fact, because one of the 7 phrases that I think was behind the way in which the 8 instruction evolved was a phrase that I think was of 9 your making which was that we were asking you to 10 express, over the period that we were interested in in 11 various different areas of healthcare administration, 12 what "good" looked like and by extension, what "bad" 13 looked like. 14 Was that the broad thinking behind the way in which 15 you went about answering the questions? 16 DR GILDER: Very much so. It was: what did "good" look like 17 at the time? 18 Q. Thank you. 19 A. Because that has changed, as you will have noted, 20 over the last 25 years. 21 Q. Indeed and therefore, a number of the questions that 22 were asked of you were to try to set out, in your 23 opinion, what important principles would be behind 24 certain aspects of healthcare administration, if it were 25 to try to achieve its objectives to the best of its Page 25	1 and I'm keen to try to understand, from your 2 perspective, where we see the phrase "best practice", 3 whether that usually means something that should be 4 aspired to as a goal or a standard that's to be expected 5 or perhaps a minimum standard in a certain area. 6 I wonder if you could help me with that and indeed 7 others may contribute if they wish to do so? 8 A. So from my perspective and from the perspective of this 9 report, "best practice" is what you aspire to practise 10 every day. But with the recognition that actually every 11 patient is different and you may need to deviate from 12 best practice in the context of what the patient 13 requires. And these days that would usually come about 14 through a multi-disciplinary team conversation. 15 Q. Okay, any other contributions on that? 16 PROFESSOR WALSH: At an organisational level, I think "best 17 practice" is what organisations are expected to aspire 18 to. It should be attainable, but it's not a minimum 19 standard. 20 Q. Yes, thank you. That's helpful. So if one views it, as 21 Dr Gilder has, from a patients perspective, are patients 22 entitled to expect best practice? 23 A. Yes, I think so. 24 DR GILDER: I do, I think so. 25 Q. And does best practice encompass in it always or Page 27
1 ability, is that right? 2 A. That's right. 3 Q. And indeed, in other areas or indeed in the same areas, 4 we asked you to set out what we call the "pitfalls", 5 things that, based on your experience, would be best 6 avoided if one were seeking to run an effective 7 healthcare administration system; is that correct? 8 A. Also to be aware of because you need to be aware of the 9 pitfalls, like how the culture within an organisation, 10 for example, or the culture that certain instructions 11 can create, or the culture that certain types of 12 leadership engenders. So pitfalls also were there to, 13 if you like, enable you to think about how you would 14 avoid them as you go into trying to establish a system 15 that works well. 16 Q. Indeed, so the theory would, in all of the areas that we'll 17 look at, to be to try to create and maintain and execute 18 systems that seek to promote the objectives and avoid 19 the pitfalls? 20 A. Correct. 21 Q. Thank you. An expression that's come up, and I think comes up 22 in aspects of the evidence that you've provided, in 23 particular one finds it in guidelines and things like 24 that, is the expression "best practice". We've seen it 25 with other witnesses and indeed with other expert groups Page 26	1 sometimes the best interests of patients? 2 A. Yes, as it's -- part of best practice is patient-centred 3 care. 4 Q. So therefore -- 5 A. And personalised care. 6 Q. Should patients then be able to expect best practice and 7 that that best practice standard should be in their best 8 interests? 9 A. Yes. 10 PROFESSOR WALSH: Yes. 11 Q. Thank you. As I say, and indeed you've said yourselves, 12 the various different aspects of the evidence that we 13 asked you to give in the different areas that you've 14 covered, would it be fair to say that over the period 15 that we are looking at, when one looks at the period 16 before, during and after, as Professor Farrell has said 17 you did, would it be fair to say that this period 18 represents a period of evolution in healthcare 19 administration, in particular an evolution which has 20 legal, political, cultural, regulatory, professional and 21 ethical components? 22 PROFESSOR WALSH: The short answer is "yes". Over the 23 period we're talking about, which spans most of my 24 career as a researcher and an academic, there has been 25 a profound change in the aspects you referred to, the Page 28

1 culture, legal, professional and other aspects. And 2 I think I'd say we have to be really attentive to both 3 the pace of that change and some particular change 4 points because we need to take account of the fact some 5 of those changes happen at a UK level and some happen at 6 the level of the four nations of the UK, but some of 7 them are in the statute, some of them are enacted in 8 policies by government, some of them are matters of 9 guidance by professional associations and others, and 10 that some of them are about the lived practice of people 11 running healthcare organisations and so being attentive 12 to that and how they changed over time I think is a core 13 concern. 14 Q. Anyone else on that? 15 DR GILDER: I think I would just add that there is also 16 a considerable impact in terms of the culture of the 17 organisation on adopting the non-statutory, 18 non-regulatory elements of what you are describing. 19 Q. So we've actually very recently in the evidence heard 20 evidence about the importance of culture in 21 organisations from a witness who came from NHS Tayside 22 and we discussed that to an extent. When you refer 23 there, Dr Gilder, to culture and that being 24 non-statutory and non-regulatory, is what you are trying 25 to say that there is a statutory and regulatory Page 29	1 statute, regulation, you're definitely seeing quite 2 a major evolution during the relevant period and into 3 the present day around the relationship between doctors 4 and patients and how that's worked out. You're talking 5 about interest before or best interest, much more of 6 a patient-centred approach, attaching importance to what 7 patients think are relevant in terms of risks and 8 disclosure, for example. And what you see at the start 9 of the relevant period and moving through the next sort 10 of 10 to 15 years is much more of a shift from -- in 11 law, I'd say, from a "doctor knows best" approach 12 towards a much more stronger -- or stronger, 13 patient-centred approach. And you see that coming 14 through in both case law and regulation, eased on, as 15 Kieran has mentioned, through various scandals 16 particularly at the turn of the millennium that led to 17 the Bristol Inquiry report. 18 So you're seeing, certainly in that first 10, 19 15 years uneven development around law. Ethics also 20 acting in lock-step. And you have heard from the 21 medical ethicists as well in that regard. So it is 22 an evolutionary process that's taking place during that 23 period around interest around a focus, much more of 24 a focus on patient-centred approach. 25 THE CHAIR: Would it be fair to describe the period before Page 31
1 framework but that framework on its own is not going to 2 produce good quality healthcare; there has to be 3 a culture that goes alongside that within 4 an organisation? 5 A. So usually with the statutory and regulatory elements, 6 those are monitored so they do happen. To varying -- 7 and then, I think in the report, we refer quite a lot to 8 tick-box exercises. So it's that. It's how is it 9 enacted? Is it enacted meaningfully or is it enacted 10 as: well, you have to an appraisal so I will have 11 five-minute conversation with you and that's your 12 appraisal done, for an example. 13 But the example I was more thinking about goes back 14 to appraisals. Appraisals have been recommended since 15 about 2001 -- Kieran will correct me if I'm wrong -- but 16 they weren't made mandatory in 2012 and from my own 17 personal perspective, I started undergoing the appraisal 18 process as it was developed in about 2003 but, at that 19 time, that would have been a decision for the 20 organisation to make rather than something that was in 21 statute. 22 Q. We'll definitely get into the details of that in due 23 course. Professor Farrell? 24 PROFESSOR FARRELL: Yes, I just wanted to add that, from 25 a legal perspective, whether looking at case law, Page 30	1 this evolutionary process came into being as "static" by 2 comparison and measurable over a long period of years, 3 or is that too simplistic? 4 PROFESSOR FARRELL: I think there was a period, you'd describe 5 from mid to late 20th century, where it was -- I mean, 6 it's talked a lot about in the literature and in case 7 law of a differential approach, certainly in the courts 8 towards medical expert evidence and towards the medical 9 profession. And that was noted in fairly -- a range of 10 cases, but even if we take -- I'm going to say the 11 Hunter v Hanley approach, but also the Bolam standard -- 12 so that sort of set the groundwork for how the dynamics 13 of the doctor-patient relationship was understood, 14 certainly in the mid to late 20th century. 15 We could talk about Bolitho, which is also 16 an influential case as perhaps putting a gloss on Bolam 17 as it's described. But again, it's been a slow 18 evolution and by the time you're getting to the great 19 Scottish cases of Montgomery and McCulloch in recent 20 times, you're seeing a much more focused approach 21 towards patient concerns and needs. But that is in 22 a way extending beyond the confines of the relevant 23 period. 24 Q. Thank you. Dr Gilder, yes. 25 DR GILDER: I just wanted to come in and just remind the Page 32

1 Inquiry, however, that the GMC guidance, Good Medical 2 Practice, 1995. And I'm going to read from it, on 3 page 4, talks about professional relationships with 4 patients. So this is 1995, and it says that: 5 "Successful relationships between doctors and 6 patients depend on trust and to establish and maintain 7 that trust you must: listen to patients and respect 8 their views; give patients the information they ask for 9 or need about their condition, their treatment and 10 prognosis; give information to patients in a way they 11 understand; and respect the right of patients to be 12 fully involved in decisions about their care." (As read) 13 And I think, whilst there is absolutely -- we went 14 to the sort of patient-centred care, you know, 15 underline, underline in bold in early 2000, it's always 16 been an expectation of a doctor to behave in this way, 17 certainly as enshrined by the very first Good Medical 18 Practice of 1995. 19 Q. Thank you. I thought this might happen, but there's 20 an awful lot of different concepts coming out of what 21 you've said, which is extremely helpful but for present 22 purposes, you mentioned Dr Gilder, that one of the 23 things that features regularly in I think all of your 24 contributions to the report, is importance of systems 25 not being "tick-box" exercises. Page 33	1 that time. 2 Q. But yet, as you've helpfully set out from Good Medical 3 Practice, which coincidentally, is the beginning of our 4 relevant period -- 5 A. Yes, it is. 6 Q. -- there were ethical obligations on doctors to conduct 7 themselves in the way that you've set out -- 8 A. Correct. 9 Q. -- despite those difficulties, that was the expectation; 10 is that right? 11 A. Correct. 12 Q. One other aspect that's become apparent from this 13 opening conversation is that another thing that you say 14 in your report in places is that it's not a good idea to 15 have different aspects of a healthcare system working in 16 silos. When reading that, it did make me reflect on the 17 fact that the Inquiry has rather asked our expert groups 18 to work in silos, at least at this stage. It was not 19 the intention that that will continue. However, 20 I'd like to give you a little bit of context from some 21 aspects of the evidence and ask you to reflect on 22 that -- and we've heard from other groups relevant to the 23 matters you have already raised. In particular, 24 relating to the way in which the law around the 25 engagement with the patient and patient-focused, Page 35
1 A. Correct. 2 Q. We'll get to the specifics of that and certain areas as 3 we go along, but is what is meant by that, that there 4 need to be systems that actually work as they were 5 intended to do within organisations rather than just 6 policies and exercises that are adhered to blindly 7 without regard to their actual purpose? 8 A. So I think what I would say is that the systems require 9 to create meaning out of this are actually quite 10 complex. And to do them well and get meaningful 11 information -- for example, I know we're going to talk 12 about clinical governance, but if we go back to the 13 doctor and how we provide our care, how we are with 14 patients, it's actually quite complex to get meaningful 15 patient feedback, for example. 16 It is quite complex -- you wouldn't think it was, 17 but it is -- to get all the reports routinely to every 18 doctor about any complaint or any adverse event that 19 they were involved with. It's much better now because 20 we have, obviously, wonderful IT systems, we have Datix, 21 et cetera. But in that period of time, the 22 infrastructure required to do this in a meaningful way 23 wasn't there. So there is something about: is it 24 a tick-box exercise or is it just very, very difficult 25 to achieve meaningfully with what we had in place at Page 34	1 individualised care has developed. 2 One thing that our ethics group told us, which 3 I think ties in with your narrative about the legal 4 development, Professor Farrell, was the way that 5 principles of this nature tend to develop -- and this 6 was the case in this situation -- is that they developed 7 from discussions in academic literature which then 8 manifested themselves in professional guidance such as 9 Good Medical Practice and the subsequent Good Surgical 10 Practice from 2002 and that then later, these were 11 manifested in law. And I think this is a progression 12 that we also see in certain aspects of the evidence that 13 you've provided to us. 14 So, in order to try to contextualise things at the 15 beginning of our period, what we were shown there is 16 that there had been a considerable body before that of 17 perhaps slightly less authoritative BMA type guidance 18 which advocated the sort of approach that Dr Gilder set 19 out, but that by the beginning of this period we had 20 that authoritative GMC documentation, Good Medical 21 Practice being the main document, which set out that 22 that was the position that required to be followed at 23 that point. 24 Now, that's the broad evidence that we've heard and 25 we've looked at lots of documents and then we talked Page 36

1 about Montgomery and the developments in the law 2 thereafter, which of course, as you will know, 3 Professor Farrell, was largely based on looking at the 4 way the ethical position had been for a number of years 5 and drawing on international jurisprudence. 6 PROFESSOR FARRELL: That's correct. 7 Q. Is that broad progression something that is consistent 8 with, in terms of the timeline, what it is that your 9 evidence tells us? 10 A. Yes. Well, just to pick up, too, on what Dr Gilder was 11 saying, the GMC guidance and Good Medical Practice was 12 fairly consistent during the relevant period in the ways 13 in which Dr Gilder highlights, it just was expanded 14 more. For example, by the time you're getting to, 15 certainly in that 2001 to 2006 period with subsequent 16 editions of Good Medical Practice, you know, a much more 17 patient-centred approach in terms of professional 18 obligations and guidance was being developed in terms 19 of -- we want to broadly call it doctor or health 20 professional regulation. So much more open 21 communication and a requirement for doctors to really 22 take account of patients' views and to attach importance 23 to it. So interestingly, by the time you get to the 24 judgment in Montgomery, in fact the GMC's guidance was 25 essentially -- I mean, I'm going to say it sort of Page 37	1 particularly the Bristol Inquiry and the 2 Dame Janet Smith inquiry into Shipman and before the 3 reforms that those Inquiries then kicked off, but it was 4 after the 1989 white paper which had, for the first 5 time, said that all doctors should be taking part in the 6 systemic critical analysis of the quality of medical 7 care. 8 So there had started to become, if you like, 9 an institutionalisation of the expectation that doctors 10 should engage with organisational systems for trying to 11 address and improve the quality of care. But if you 12 read the research literature at the time, things like -- 13 and I think we cited it, Liam Donaldson's work who was 14 the regional medical officer in the northern region, his 15 work on problem doctors, Marilynn Rosenthal's book about 16 the handling of cases of concern, the lived experience 17 was that those problems were still dealt with often 18 through informal, social, and professional mechanisms 19 designed to, you know, circumvent or remove the problem. 20 But they were much less commonly dealt with by, if you 21 like, the formal systems that were in place, the GMC 22 processes for tribunals, but also the Department of 23 Health guidance on managing doctors with problems. 24 Ian Kennedy, in his 2001 Inquiry report, talks at 25 length about the club culture of medicine at that time Page 39
1 fairly loosely, but adopted in terms of that commitment. 2 So you're seeing, in this period in terms of the 3 chronology, in fact professional regulation and guidance 4 being much more at the forefront of the evolving, more 5 patient-centred approach. And then, quite rightly as 6 you see in the court action, you're waiting for a set of 7 facts to come before the courts before the pronouncement 8 can be made. But in terms of soft law, guidance and 9 practice, it was in place at a much earlier stage than 10 you would see in formal court judgments. 11 Q. There was a specific matter I was going to ask you 12 about, Professor Walshe, but if you'd like to contribute 13 to that, it would be very helpful. 14 PROFESSOR WALSH: No, go ahead with the specific matter -- 15 Q. (Overspeaking) I was going to ask you, given that 16 background which comes more from, I think, the area 17 Professor Farrell has expertise in, the ethical and 18 legal background, to try to convert that into 19 an organisational responsibility, was it incumbent upon 20 organisations to deliver systems in which doctors were 21 able to comply with that developing individualised 22 responsibility? 23 PROFESSOR WALSH: It's a moving landscape at that time. 24 The start of the relevant period in the mid-1990s was 25 a point before some of the significant Inquiries, Page 38	1 and the tendency of the profession to protect its own 2 and I think that was still very alive and well in the 3 1990s. 4 Q. That's very helpful indeed, but just to put that in our 5 timeframe. When you mention the Kennedy report, that's 6 the report in the Bristol Inquiry, is that right? 7 A. Yes. 8 Q. That came out, I think, in 2001? 9 A. Yes. 10 Q. You were involved in giving evidence to that Inquiry, 11 I think, is that right? 12 A. Yes. 13 Q. And are you saying that, in the aftermath of an Inquiry 14 such as that, there was a move away from that club 15 culture as a result of it? So are you really focusing, 16 for our period, are you talking about from 1995, where 17 our relevant period starts up till the early noughties, 18 if I can put it that way, there was still a lingering 19 club culture, as you put it, despite, for example as 20 Dr Gilder has pointed out, Good Medical Practice having 21 come out in 1995? 22 A. I think Dr Gilder will be better placed than me to 23 discuss the lived experience on the ground of medical 24 directors and doctors. I would say the club culture 25 persists. It's still -- if you look at much more recent Page 40

1 cases, it's still an issue that it has been difficult to 2 get problems around doctors whose practice gives cause 3 for concern dealt with effectively and in a timely 4 fashion. But the Bristol case, the scandal around 5 paediatric cardiac surgery, the striking off of the 6 chief executive of the trust who was a radiologist for 7 his practice as a manager, not for his practice as 8 a clinician, and the subsequent reforms that arose out 9 of the Bristol Inquiry, particularly the creation of 10 a system for organisational regulation -- what was then 11 the Commission for Health Improvement -- that is 12 a turning point, I think, in the extent to which 13 healthcare organisations and their leaders were expected 14 to take formal and corporate responsibility for ensuring 15 the quality and safety of care. 16 Q. But to be clear, those expectations predated that in 17 terms of what they should have been doing, is that fair? 18 A. I think it's fair to say that they existed in policy. 19 They didn't really exist in hard statute. 20 Q. Okay. One other aspect of the other evidence that we've 21 heard from the other groups that I wanted to ask you 22 about in order to try and orientate ourselves in time is 23 that one of the members of our neurosurgical group, 24 Mr Redfern, gave some evidence to us about the way that 25 he viewed things in 1995 -- he was a consultant Page 41	1 I would have known that. I can't say now whether I can 2 recall whether that was by statute, but that was what 3 the practice was. That, you know, these things are 4 important to patients." (As read) 5 So in trying to orientate in the field, as 6 Professor Walshe has suggested we should do, his 7 impression was that -- he had been a consultant for 8 a few years before that and he recognised what he 9 described as a paternalistic culture of medicine, where 10 the doctor would choose the treatment, if you like, but 11 that he saw this as a period where things had changed 12 within neurosurgical practice. I wonder whether you 13 might be able to help us with reflecting on whether 14 that's something that you would accept or that's 15 something that you think is -- your timeline would be 16 different from that? 17 DR GILDER: So I was a senior house officer in 1995 and in 18 that period of time I worked in five hospitals, so I can 19 only speak from my own personal experience. And I would 20 say two things. One, the patients commonly very much 21 looked to the doctor to make a decision on their behalf. 22 And that does still, to a much lesser extent, exist in 23 the slightly older population of patients: you're the 24 doctor, you tell me. Quote, unquote. So that's the 25 first thing. Page 43
1 neurosurgeon at that time -- in the context that we were 2 discussing. And in particular, I asked him some 3 questions about the fact that in the report he had 4 talked about there being a paternalistic culture at some 5 stage. And I had asked him questions in relation to 6 whether he felt that that paternalistic culture still 7 persisted in 1995 or had passed specifically within the 8 field of neurosurgery. So I asked him: 9 "I wonder, Mr Redfern, whether you have any 10 reflections on that area, more from the era in terms of 11 decision-making around what surgeries might be offered 12 to an individual patient and whether the practice, over 13 the period we're particularly interested in, would be 14 [as one of his colleagues had suggested] in the area of 15 that surgery for this problem and there being less 16 consideration of the individualised circumstances, 17 attitudes or views of the patient." (As read) 18 And he was of the view, at the start of the period, 19 that: 20 "I think we were very much of the time at that time 21 that the patients were involved in the decision-making 22 process, the age of paternalism had gone. So patients 23 were involved, we would discuss what the risks of 24 a particular procedure were, what the benefits were, 25 what the alternatives. I mean, I can't say whether Page 42	1 But the second thing is very much all the practice 2 I experienced -- and as an anaesthetist, you work with 3 a lot of surgeons, that's who you work with, hundreds 4 and hundreds -- and my huge experience -- and it is 5 a vast experience -- would say that the patient was very 6 much involved in those conversations. 7 THE CHAIR: Sorry, the patient was very -- 8 DR GILDER: Was. Was. 9 MR DAWSON: Thank you, that's very helpful. Any other 10 reflections on that before we move on? 11 A. I think there's one more thing. I think the other thing 12 we need to remember is this is often person-specific or 13 consultant-specific and there are consultants who took 14 a particular approach and other consultants who took 15 a not a particular approach and that often would be 16 associated with the age and the training background of 17 that consultant. So the older consultants -- and this 18 is an absolute generalisation but is my experience -- 19 found it a challenge, or a debate about care 20 uncomfortable, in those days. 21 Much less so now where, as again, multi-disciplinary 22 teams and that whole approach, that all came in over my 23 clinical career and than shift from physician autonomy: 24 I'm the doctor, I make the decision, to: we're a group, 25 we make the decision together, was an absolute culture Page 44

1 change. And I think we all have to remember, doctors 2 are trained to be the one who makes the decision but 3 also bears the consequences of that decision. And that 4 creates a set of behaviours and in a proportion of 5 doctors make it difficult when their decisions are 6 challenged because you're under an extreme pressure 7 to – because you are the one, you are the final. And 8 of course, if you combine that with a blame culture, 9 which you'll have heard about, which we all experienced 10 for a very long time. So I think there's something 11 about what creates culture, why it's like that, what is 12 a culture of your – and remember, an organisation doesn't have 13 one culture, it has multiple cultures and those 14 micro-cultures will be within a department of 15 neurosurgery or a department of anaesthesia or whatever, 16 or within a particular managerial layer. So what 17 I'm trying to illustrate is there are quite a lot of 18 complexity within this conversation, which is individual, 19 departmental, organisational and then sociopolitical. 20 Q. Thank you. You recognise, I think, in that helpful 21 contribution, Dr Gilder, that there were, as we've 22 identified, perhaps a time period -- one might fix it at 23 slightly different years, but there was a time period of 24 evolution going on around about this time; is that 25 broadly correct? Page 45	1 be things that are beneficial to patients and beneficial 2 to the good of the healthcare system, is it important 3 that in circumstances where the phenomenon that 4 Dr Gilder has described is happening, that the system 5 tries to make sure that doctors go along with these 6 evolutionary changes? 7 PROFESSOR WALSH: Yes, and I think medical sociologists 8 would probably say that: oh, this long period, this 9 relevant period that you're describing, there has been 10 an ongoing kind of exchange between the profession and external 11 actors like government and others, but also within the 12 profession between what some would describe as the 13 professional elite and the mainstream of the profession. 14 The arrangements for the governance of the 15 profession, which relied really until -- certainly, 16 until some time into the relevant period, on a model of 17 self regulation, have changed to create a model which 18 relies much more on a kind of stratified form of 19 governance in which the profession governs itself, or 20 continues to have a big role in governing itself, but 21 where senior members of the profession take 22 responsibility for overseeing the practice of the 23 mainstream. And that has been a much contested 24 development. Some of the reforms, which I'm sure we 25 will get on to, have been unpopular with the mainstream Page 47
1 A. Yes, absolutely. 2 Q. And you brought out a helpful component of it, if 3 I remember correctly, but perhaps Professor Walshe 4 answered questions about this -- and we might ask him 5 his view in a minute -- but one of the aspects that 6 I think is significant to what you said is that there 7 were some people who went along with that culture change 8 and perhaps some people that didn't. Are you referring 9 to the fact that there were some doctors who perhaps 10 were trained in a different tradition, who were 11 resistant to the innovations? 12 A. I think it was to do with when they were trained, in 13 terms of the years. So the older -- going back to the 14 older consultants' experience is a very different type 15 of training to the training our doctors receive and 16 experience now, on the whole. 17 Q. One aspect that makes me think of something -- I think 18 it was you, Professor Walshe -- you talk about the need 19 to guard against we've mentioned deference to doctors, 20 but also an assumption of competence in doctors, 21 I think, in one of the passages of the report. I think 22 it was you that talks about that. Is it therefore 23 important that doctors -- given that these changes are 24 being done for what is perceived from a regulatory, from 25 an ethical and, in time from a legal point of view, to Page 46	1 of the profession who have seen it as more work, 2 a bureaucracy, and an interference in their professional 3 identity and autonomy as a doctor who has, you know, 4 spent a lot of time training. 5 But I don't think you can underestimate just how far 6 we have come from a world in which the GMC, for example, 7 oversaw your standards for education, put you onto the 8 register and was then never concerned with you as 9 a doctor unless serious complaints were made about your 10 practice. And had a very distant relation to 11 organisations who employed doctors. We've come a very 12 long way to a system in which there is an ongoing 13 oversight of the fitness to practise of doctors and 14 a much closer engagement between organisational and 15 professional regulation. And that's really all happened 16 over the time that you're describing as the relevant 17 period. 18 Q. Thank you. One other aspect of the evidence that that 19 puts me in mind, we heard from some representatives of 20 the GMC -- I think there's reference to this, perhaps in 21 one of Professor Farrell's passages -- but we were told 22 about there being an evolution in the GMC's attitude 23 towards things which was marked, again as it happens, 24 broadly by the beginning of our relevant period. And 25 I think, as a physical manifestation of that, we were Page 48

12 (Pages 45 to 48)

1 pointed towards the fact that Good Medical Practice that 2 came out in 1995 had been predated by something else. 3 Again, I think Professor Farrell mentioned this in the 4 report, called the Blue Book? 5 PROFESSOR FARRELL: The Blue Book, yes. 6 Q. Yes, and when one compared one volume with the other, we 7 were told by a representative of the GMC, that one was 8 able to see an evolution in the role that the GMC was 9 playing, from one that was really about: here are the 10 things you're not allowed to do, to one which was about: 11 here are the standards to which you should aspire. And 12 is that broadly the sort of evolution -- it may not be 13 marked at that particular moment in time, but the sort 14 of evolution that you're describing, Professor Walshe? 15 PROFESSOR WALSH: Yes, I think if you look at the evolution 16 of Good Medical Practice itself over the -- I think it's 17 about five or six editions it's been through, you see 18 a gradual broadening of the scope of it, to encompass 19 a more structured idea of the sets of attributes of good 20 professional practice but also to broaden it beyond 21 technical competence to relational and social skills and 22 behaviours, not just with patients but also with 23 colleagues. And that has, at times, been resisted by 24 the profession who felt that, you know, there's a kind 25 of regulatory creep at work in which the scope of what Page 49	1 accountability, but also to see doctor-patient relations 2 as differentiated, so that it's not -- you know, they 3 don't arrive in a neutral spot, that there are different 4 sorts of patient groups, that there are different sorts 5 of specialties and doctors. And understanding what that 6 means in terms of guidance and expectations as well. So 7 I think that's much more pronounced during the relevant 8 period and really from quite early on. 9 Q. Is the increasingly interventionist role, I think, you 10 said of the regulator designed to try to deal with some 11 of the resistance that both Dr Gilder and 12 Professor Walshe has pointed out, is it the case that 13 where there is an evolution in the healthcare system in 14 all of these different guises, legal, ethical, cultural, 15 that it's not acceptable for people not to go along with 16 it? 17 A. Yes. I mean, I think that Dr Gilder and 18 Professor Walshe have highlighted I think quite well, 19 the cultural issues at stake. They don't work in 20 isolation from changes in law and ethics and from 21 tribunal and inquiry reports, et cetera. But it's 22 a complex relationship in the context of the National 23 Health Service. There's a famous paper by Rudolf Klein, 24 who I'm sure Kieran knows about too, called "The 25 politics of the double bed" and that's published at the Page 51
1 we're being asked to sign up to in Good Medical 2 Practice -- going back to your point that it's not just 3 an aspiration, it is setting out what doctors should do. 4 PROFESSOR FARRELL: I just would add too, certainly in the 5 academic context in the research, in the area we study 6 medical law and ethics together and at the heart of that 7 has been -- a focus has been on doctor-patient relations 8 over decades. So we do look to the law, the ethics and 9 a lot of what's highlighted in Good Medical Practice is 10 good ethics and I'm sure that came out in terms of what the 11 medical ethics expert group was saying. But a lot of 12 medical ethics and perhaps what doctors would identify 13 as such is infused with law and regulation nowadays. 14 And in terms of the evolution from the mid-1990s, you 15 can see not only the scandals and the reports that 16 followed from it, but for example, the Human Rights Act 17 and equality legislation or anti-discrimination 18 legislation. A lot of what might be seen as medical 19 ethics or professional obligations set out in GMC 20 guidance is infused with law. 21 And also -- and that began to happen really, I would 22 identify, from the turn of the millennium and you see 23 that in the evolution of GMC guidance. And also 24 a requirement that regulators are much more activist in 25 terms of expanding the remit, ensuring trust and Page 50	1 start of the 1990s and it talks about, you know, the 2 relationship between the profession and the state, and 3 its importance for the functioning of the National 4 Health Service. So you've got a range of actors, you 5 have got the state, you've got the profession which is 6 very much used to peer or self-regulation, and then 7 a regulator essentially, you know, you're on the 8 register and then you're not really troubled after that, 9 except in specific circumstances. 10 So you're seeing an evolution in thinking, 11 particularly I would track from the turn of the 12 millennium, and changes just more broadly in law and how 13 we understand that relationship. But it's a complex and 14 I'm sure -- a complex interaction of institutions, 15 management, changes in law and ethics and how the 16 profession views itself. 17 Q. Thank you. I wonder, Dr Gilder, just in relation to the 18 matters we've been discussing, to try to tie in 19 a particular concept that's come up quite a bit in the 20 evidence we've heard already, that this evolution that 21 we've been talking about and a move away from 22 a paternalistic, "doctor knows best" type attitude, is 23 part of that -- in a practical sense within a hospital 24 environment, does that require to manifest itself in 25 a realisation that one should not simply defer to Page 52

1 a doctor's view but that that requires to be subjective 2 to some level of external scrutiny? 3 DR GILDER: I'm not sure I understand exactly what the 4 question is. 5 Q. I'm trying to explore whether, in the context of this 6 evolution, the circumstances in which one would simply 7 defer to a doctor to make a decision, should become 8 less. Because there are a number of other agencies, be 9 they individual patients, be they the regulator, be they 10 other bodies, legal bodies, who now have an increased 11 role in trying to oversee and regulate the way in which 12 doctors conduct themselves. And particularly, the 13 context in which you pointed out earlier, that there may 14 be older doctors who are resistant to the changes, are 15 we trying to move away from a culture in which one 16 simply defers to the doctor knowing best? 17 A. We are. So what I'm struggling with is the concept of 18 clinical decision-making and the patient that is in 19 front of you and trying to do the right thing by the 20 patient. When the patient is complex or the options are 21 complex, in those environments one would expect there to 22 be taken to colleagues -- I mean, I have spent -- I set 23 up a multi-disciplinary clinic to decide: how do we look 24 after older patients who may not be fit for surgery, and 25 there is a framework called BRAN, which is "benefits", Page 53	1 relevant period, was the era when the term 2 "evidence-based medicine" became very prominent in the 3 professional and academic literature and in practice. 4 And this was driven by both some ideas about 5 a recognition that quite often clinical practice was 6 quite some way from what research told us and best 7 evidence told us we should be doing, but also that in 8 almost every area where you looked, you found wide 9 variations in clinical practice and it was very hard to 10 argue that every clinician's choices were the right 11 choices when you found so much variation, that couldn't 12 really be substantiated by differences in patients or in 13 patient choice. 14 So there were some very high-profile examples of 15 low-value surgery, for example, that were used to say: 16 well, why are we doing grommet operations in children 17 with glue ear? Or: why are we doing so many 18 third-molar, wisdom tooth extractions in asymptomatic 19 cases when the evidence says that this is not a good use 20 of resource? 21 There are variations examples such as, at that time, 22 orthopaedic surgeons were using a huge array of 23 different hip prostheses and most of them had quite poor 24 evidence for their long-term outcomes. So this 25 developed into an institutionalisation, if you like, of Page 55
1 "risks", "alternatives", "do nothing", for example. So 2 that is meant to help clinicians, not just doctors, 3 explore options for patients and that is a much more 4 recently involved in terms of taking a structured 5 approach. 6 So I think my answer would be we should never assume 7 that the doctor knows best, but -- but we also need to 8 recognise the doctor may have significant expertise. 9 And so you're not going to sit there and say: this is 10 the right thing -- for me, I'm trying to interpret how 11 you would do that in real life, what we're describing. 12 So, for me, it's understanding the competence of the 13 doctor. And these days actually it's not that 14 difficult -- I suppose it depends where you are. But 15 I'm answering this very clumsily, but I think your 16 question is quite complex because I don't believe in 17 deferring to doctors, but I also believe that clinicians 18 have expertise and that certain decisions like if you 19 have a hernia, you need a hernia repair, is fairly 20 obvious, if you like. So I think it depends on what it 21 is the patient is presenting with. 22 Q. Thank you. Yes, please, Professor Walshe. 23 PROFESSOR FARRELL: I would add -- sorry, no, you go. 24 PROFESSOR WALSH: I was going to add at a more macro level 25 that at this period, particularly at the start of the Page 54	1 clinical guidelines, really best exemplified by the 2 creation of NICE, the National Institute of Clinical 3 Excellence in England and its equivalence in Scotland, 4 SIGN, and in the other nations, to provide much 5 stronger, evidence-based guidance to clinicians which 6 then clinicians -- whilst that guidance was not 7 mandatory, clinicians, if they wanted to diverge from 8 that guidance, had to increasingly provide really good 9 explanations for their divergence. And I think Fay 10 would probably be well placed to comment on how NICE's 11 impact played out in the profession. 12 DR GILDER: Well, enormously in terms of the options that we 13 have in terms of recommended treatment. So 14 tonsillectomy is another really good example, there's 15 lots. And it's very helpful guidance. I'm still struggling 16 with the deference question because it's so contextual. 17 PROFESSOR FARRELL: If I could just add, from a legal 18 perspective, we would probably differentiate between, 19 for example, patient -- sorry, information disclosure 20 versus diagnosis versus treatment. And the extent to 21 which you've got interests at stake, would be -- perhaps 22 not used today -- paternalistic approach or the need to 23 acknowledge that you've got somebody with expertise 24 making a decision around a clinical or matter of 25 judgment. And you can see the courts increasingly Page 56

1 outside really the relevant period, in the last 10 to 2 15 years, really grappling with that in much more 3 detail, given the facts, circumstances, coming before it 4 around what does the -- exactly what needs to be disclosed, 5 what are the percentages we might need to be dealing 6 with, perhaps drawing on a range of other evidence 7 bases, rather than seeing it as a clinical sort of term 8 of art, for example. 9 So, you know, I think this is, even during the 10 relevant period, even beforehand, that differentiation 11 between, yes, information disclosure, about risk, 12 et cetera, diagnosis and treatment, and the law in this 13 country being able to deal with that differentiation. 14 MR DAWSON: Thank you. Sir, that would be a convenient 15 moment for a break. 16 THE CHAIR: Right, we'll take 15 minutes just to draw breath 17 and we'll resume again by 25 to 12. One housekeeping 18 matter to mention because all three of you obviously 19 started giving evidence and to keep matters regular, we 20 do ask that you don't discuss your evidence outwith your 21 own number while we have these breaks, but we'll see you 22 back here in quarter of an hour, thank you. 23 (11.21 am) 24 (A short break) 25 (11.42 am) Page 57	1 were offered in Scotland. And you've helped us with 2 understanding in particular that during our relevant 3 period, there are a number of important changes, not 4 least of which was the advent of devolution in 1999. 5 You also have told us that -- a matter that we 6 covered actually with a witness just yesterday -- that 7 there had been a period before that of something I think 8 you tell us was called "administrative devolution". 9 Could you just broadly spell out for us what that meant 10 in terms of whether the change of the control of 11 healthcare, at the advent of the Scottish Parliament, 12 was as major a change as it might appear to other people 13 or whether there was a degree of continuity in the way 14 it was offered in Scotland over that period? 15 PROFESSOR FARRELL: Yes, I would say Scotland was quite 16 unique in terms of -- well, let's call them the devolved 17 nations -- in terms of having, on an administrative 18 devolution basis, quite a degree of independence in 19 terms of the management of NHS in Scotland. So 20 henceforth, the sort of administrative devolution. 21 You'd perhaps compare it to Wales and even Northern 22 Ireland and the position would be quite different. 23 So what I would say though is, as a result of 24 political devolution and the explicit devolution of 25 health competence to Scotland, what you see is much more Page 59
1 THE CHAIR: Right, when you're ready. 2 MR DAWSON: Thank you, sir. I'm going to now move on now to 3 some of the specific aspects of your very helpful 4 report. Before doing so, as I think you're aware 5 already but just for the benefit of everybody else, all 6 of the material in your very helpful report and the 7 materials you've provided with the report are already 8 evidence in the Inquiry, so they will all be part of the 9 material which the Chair will take into account in 10 drawing his views together within he writes his report. 11 What I would like to do, in particular as your 12 evidence comes toward the ends of our section 1 13 hearings, is to focus in on certain areas that you have 14 helped us with but which we haven't perhaps focused in 15 on as much in other areas. So there are some areas 16 which you have already given your evidence about where 17 we've heard quite a lot of evidence already, but 18 I intend to focus on some parts where you've, as I say, 19 already been helpful and I think you continue to be 20 helpful, but on which we haven't heard quite as much. 21 So what I'd like to start with, is I think this is 22 for you, Professor Farrell, to start off. You have, 23 helpfully in the report included, in response to some of 24 our initial questions, you've set out for us the legal 25 framework in particular in which healthcare services Page 58	1 dramatic changes, I would say, from that period in terms 2 of really taking charge and being more responsive to 3 local communities and what was needed. But of course, 4 as you see from the documents, it didn't happen 5 overnight. So you're seeing, particularly in the early 6 noughties and through to about 2010, 2011, the Scottish 7 Executive, then the First Ministers, et cetera, well, 8 Scottish Government, setting up a range of Scottish 9 bodies to manage oversight and management of the health 10 service. And also re-organising, I suppose, the 11 Scottish health system to set up a territorial board 12 system as well. 13 So you're getting much more -- I'm sure in political 14 terms they would call it much more distinctive Scottish 15 approach, that is more responsive to the local needs. 16 But it taking place really over, I suppose, the latter 17 half of the relevant period that you would be concerned 18 with. 19 So always a degree of independence, particularly on 20 administration levels, but much more controlled from 21 a higher political level, to set the direction of the 22 health service in Scotland from the time of political 23 devolution. 24 Q. Thank you. Are there any sort of landmarks that you 25 could give us? You talked about, for example, Page 60

1 particular changes towards the end of the period, things 2 like the Patient Rights (Scotland) Act, which I think 3 was in 2011. Would that fit in with the analysis you've 4 given of something coming along later that was something 5 that had been delivered through the Scottish Parliament 6 that had a particular effect on the landscape? 7 A. Yes, well, just to sort of highlight a few examples -- 8 Q. That would be helpful. 9 A. -- so, no doubt my colleagues will talk about it in more 10 detail because it's within their areas of expertise. 11 But, for example, there is quite a seminal statement 12 document, it's known as a circular, coming out in 1998 13 about clinical governance in the Scottish -- 14 NHS Scotland about moving ever so slowly from, you know, 15 peer or self-regulation towards health boards and the 16 executive boards being responsible for clinical 17 governance in health boards in Scotland. So that was 18 quite major and that was coming from obviously in 19 a pre-devolution phase, so it is an example of quite 20 activist sort of administrative devolution. But what we 21 also see, particularly in the noughties, is a creation 22 of a range of, I suppose, quality improvement or health 23 and safety initiatives. And I want to highlight a few 24 of those. For example, the patient safety programme 25 which began in Scotland in 2007 and was really the first Page 61	1 was setting out the organisational arrangements in part 2 for NHS Scotland. What you tend to find on a UK-wide 3 basis, even during this period and well beyond, is that 4 you have regular periods of time where the governments 5 sort of adopt legislation to engage in structural 6 organisational reforms, set out principles that govern 7 the operation of health services and how things are 8 organised. 9 Q. Okay, so if we can just have a look at some of the 10 provisions which set out the bare bones of this. In 11 particular, you mentioned already health boards, but 12 we're interested in the role of health boards in the way 13 NHS Scotland operates and I think this Act helps with 14 that to an extent. If we just look at section 1. 15 Scroll down a little bit, please. Do we see here that 16 this imposes a general duty on the Secretary of State, 17 where it says: 18 "It shall continue to be the duty of the Secretary 19 of State to promote in Scotland, a comprehensive and 20 integrated health service designed to secure ... 21 "(a) improvement in the physical and mental health 22 of the people of Scotland, and ... 23 "(b) the prevention, diagnosis and treatment of 24 illness ... 25 "... and for that purpose to provide or secure the Page 63
1 of its kind, on a UK-wide basis, but you also had 2 a range of different bodies that were being established 3 from the time of political devolution to oversee that. 4 So obviously, you know, Healthcare Improvement Scotland 5 was established in 2011 but there were precursor bodies 6 and it was part of an evolution around patient safety 7 and quality improvement that took off from the time of 8 political devolution, that became much more politically 9 driven, centrally operated and much more increasing 10 oversight of health board activity from the time of 11 political devolution that went to both structural change 12 as well as policy and organisational change, 13 particularly relating to quality and safety. 14 Q. Okay, thank you. I wonder if we could put that change 15 into some context. One thing that we've heard quite 16 a lot that we've not looked at yet that you help us with 17 in your report is the National Health Service (Scotland) 18 Act 1978 that forms, to some extent, a background to the 19 developments that you just talked about. So I'd just 20 like to have a little bit of a look at some of the 21 provisions of that, that you can help us with, I think. 22 NHST-04332, please. So what's the significance of this 23 Act in terms of the way that the National Health Service 24 operates in Scotland? 25 A. Well, I'd have to have a more detailed look at it but it Page 62	1 effective provision of services in accordance with the 2 provisions of this Act." 3 And under subsection (2): 4 "... The services so provided shall be free of 5 charge, except insofar as the making and recovery of 6 charges is expressly provided for by or under any 7 enactment, whenever passed." 8 So fundamentally at this time at least, in 1978, the 9 main obligation is on the Secretary of State to run the 10 health service and I think, in terms of the helpful 11 narrative you gave a moment ago, this responsibility is 12 then passed on at a later stage to the Scottish 13 Ministers as the Act says, known as, as you told us, the 14 Scottish Executive initially and then by 2007, the 15 Scottish Government, is that right? 16 A. That's correct, yes. 17 Q. And if we just look at some of the other provisions here 18 that are helpful to matters that we've touched upon. If 19 we look at section 18, please, which is at page 11. 20 Does section 18 tell us that there's a further duty here 21 related to the provision of general medical services, 22 where it says: 23 "It shall be the duty of the Secretary of State to 24 secure the provision of general medical, general dental 25 and general ophthalmic services, and of pharmaceutical Page 64

1 services, in accordance with the provision of ..." 2 Part 2 of the Act, is that right? 3 A. Yes. 4 Q. Then, if we look back -- jumping around a bit, I didn't 5 design the act -- back to section 2, please. This, 6 I think, is the section which basically creates health 7 boards, is that right? 8 A. Yes. 9 Q. And you told us, in your report, something that we've 10 heard a little bit about in a specific Tayside context 11 but you've given us a bit more information about, is 12 that effectively what this section does is it creates 13 health boards and it creates the power in the Secretary 14 of State to be able to designate health boards and the 15 areas in which they operate, I think broadly, that's 16 correct, by regulations -- 17 A. (Overspeaking) Yes, obviously there were changes over 18 time to make that much more explicit but the general 19 sort of organisational rubric, yes, is set out in that 20 regard. 21 Q. Absolutely and I think the changes that happened, 22 I think you help us with this in the report, we've heard 23 a little bit about this, as I say, in the Tayside 24 context. What we've heard is from the beginning of our 25 relevant period in 1995 until 1999, there was the health Page 65	1 A. Yes, definitely. 2 Q. I think, by 2004 -- 3 A. 4, that's correct. 4 Q. -- things are simplified, to an extent, by the fact we 5 have Tayside -- 6 A. (Overspeaking) Yes, and I'm just going to turn to my 7 colleague, Fay, about the trust arrangements versus the 8 boards too, because my recollection is you may have 9 something to add, no? 10 DR GILDER: Not in the context of the Scottish health 11 system. I don't have experience with the Scottish 12 health system. 13 Q. Yes, trusts -- 14 PROFESSOR FARRELL: (Overspeaking) Yes, okay, just to 15 confirm -- 16 Q. -- are a common feature in the English system, as I -- 17 DR GILDER: (Overspeaking) They are and those are 18 foundational trusts and are not -- but they're not 19 relevant in the Scottish context. 20 Q. Thank you very much. 21 PROFESSOR FARRELL: Just to confirm that, I wanted to check 22 with my colleague. 23 Q. No, I appreciate that. Thank you very much. And as far 24 as you understood these arrangements which, as you've 25 told us, you do set out in the report, as far as the Page 67
1 board that had been constituted under this Act with the 2 responsibilities that we'll look at in a minute but 3 there was also something called Dundee Teaching 4 Hospitals NHS Trust -- 5 A. (Overspeaking) Yes, we do note that in the report. 6 Q. Yes, you do. And then subsequent to that, in 1999, you 7 also told us that there was a change and another 8 organisation called the Tayside University Hospitals NHS 9 Trust came along. And those trusts were involved, as 10 I understand it from the report, in running the 11 operational aspects of healthcare provision in the NHS; 12 is that right? 13 A. Yes. I just would just provide some background context 14 in that regard. Obviously before political devolution, 15 you've got that mixture -- I mean, the NHS goes through 16 success of periods of organisational reform, but that 17 use of the trust versus the board and different sort of 18 aspects of responsibility being assigned in that regard, 19 both as legal entities, as corporate responsibility, 20 et cetera. But what you see, post political devolution, 21 is the removal of that particular arrangement, and much 22 more of a focus on territorial arrangements of health 23 boards. 24 Q. Indeed, although it appears to have happened in 25 different iterations in the early stages? Page 66	1 service provision is concerned presumably during the 2 trust era, if I can put it that way, which is the 3 beginning sort of nine years really of the period that 4 we're looking at, did the fact that there were trusts 5 involved in the delivery of health services at that time 6 make a massive difference to what, for example, 7 a patient might experience, or was that really just 8 an administrative arrangement by which the government 9 thought that things should be delivered? 10 A. I really couldn't comment on it from the patient 11 perspective and again, we're looking at a time of change 12 with governmental responsibility being quite diverse in 13 this era. So it would be outside my expertise to talk 14 about that. 15 Q. (Overspeaking) Okay, thank you. If we go back to 16 section 2, please, we see there "Health Boards", it 17 says: 18 "The Secretary of State shall by order constitute in 19 accordance with Part I of Schedule 1 boards for such 20 areas as he may by order determine, for the purpose of 21 exercising functions with respect to the administration 22 of ... health services provided by him as he may so 23 determine, and for the purpose of making arrangements on 24 his behalf for the provision of the services mentioned 25 in Part II; and those boards shall be called Health Page 68

1 Boards." 2 And we know that the health board in which we're 3 interested is Tayside Health Board. Section 2(2) says: 4 "The order or orders made under subsection (1) 5 determining the areas for which the Health Boards are to 6 be constituted shall be separate from the order or 7 orders constituting those Boards; and, before making any 8 order determining such an area, the Secretary of State 9 shall consult with such bodies and organisations as 10 appear to him to be concerned. 11 "(3) The Secretary of State may by order vary the 12 area of any Health Board, whether or not the variation 13 involves the constitution of a new [health] Board ..." 14 And it says, under (6), that the: 15 "Regulations ... shall make provision requiring each 16 Health Board to submit to the Secretary of State 17 a scheme for the exercise of their functions ..." 18 And that, under (8): 19 "A Health Board shall ... be entitled to enforce any 20 rights acquired, and shall be liable in respect of any 21 liabilities incurred ... in the exercise of those 22 functions in all respects as if the Health Board were 23 acting as a principal; and all proceedings for the 24 enforcement of such rights or liabilities shall be 25 brought by or against the Health Board in its own name." Page 69	1 In various different ways: 2 "For the preparation and publication of lists of 3 medical practitioners who undertake to provide general 4 medical services ... 5 "for securing a right to any person to choose or to 6 change ... the medical practitioner by whom he is to be 7 attended ..." 8 And various other provisions relating to that 9 service. So is this effectively explaining that general 10 medical services will be provided by health boards, and 11 that the Act, I think, also provides for the fact that 12 as well as primary medical care, hospitals effectively 13 would be run by health boards as well? 14 A. It's fairly general, but general medical services would 15 come within that understanding of hospitals and their 16 operations. 17 Q. Excellent, thank you. One other thing that I just 18 wanted to point to, because it's something that's some 19 come up in the evidence that we've heard already. If we 20 go to section 14, please. No, actually, we'll just 21 leave that and come back to that later. So this is the 22 general statute in which you've described -- and you've 23 told us that things -- and you do, in the report in some 24 detail, that things moved on in 1999. 25 As far as the responsibilities of health boards are Page 71
1 So do these provisions effectively entitle the 2 Secretary of State to decide which areas of Scotland 3 will be covered by which health boards but it also 4 points out that the health boards will then be 5 responsible for the operation, in accordance with the 6 Act, of the way that the healthcare services are 7 delivered for that area? 8 A. Yes, that's certainly what's stated in the legislation. 9 Obviously, no doubt, evidence will be gathered by the 10 tribunal as to how that worked in practice. 11 Q. Yes, of course. And if we could go, then, to 12 section 19, page 11. This was the section we were 13 looking at a moment ago which now sets out, under 14 section 19, the arrangements and regulations for general 15 medical service. It says: 16 "It shall be the duty of every Health Board ... to 17 make as respects their area arrangements with medical 18 practitioners for the provision by them of personal 19 medical services for all persons in the area who wish to 20 take advantage of the arrangements; and the services 21 provided in accordance with the arrangements are ... 22 referred to as 'general medical services'." 23 And then it sets out that the: 24 "Regulations may make provision for defining the 25 personal medical services ..." Page 70	1 concerned, you've told us that there were various 2 consequences of healthcare being a devolved matter but 3 you also tell us that under the legislation which 4 brought about devolution, the Scotland Act 1998, there 5 were certain matters that relate to healthcare that were 6 not devolved to the Scottish Parliament and I wonder if 7 you could tell us how that operates in practice and 8 we'll look at some of those areas in a little more 9 detail? 10 A. Sure, they're certainly under the context of the 11 political devolution settlement at the time, there were 12 certain matters -- and the legal term of art is used 13 "reserved to Westminster" and one of them just as 14 relevant for the tribunal, is of course professional 15 regulation and doctors regulation, that's UK-wide and 16 therefore, for example, despite devolution of health 17 competence in Scotland, the regulation of doctors would 18 have been UK-wide and managed by the GMC. 19 Q. So the regulation of healthcare professionals including 20 doctors are reserved to the UK Government and that would 21 include -- we've mentioned the General Medical Council 22 already, that body and its operations were, at the time 23 of the devolution settlement, and remain, part of the remit 24 of the UK Parliament and government, is that right? 25 A. That's correct and for example -- and we do note it in Page 72

1 the report, the GMC ended up setting up a separate office 2 here after political devolution in 2003, in 3 acknowledgement of course of devolution but the 4 importance of a local presence in terms assisting health 5 boards and doctors with their regulatory 6 responsibilities in that regard. 7 Q. Absolutely. We've heard from some representatives of 8 the GMC who were very keen to point that out as well and 9 indeed, when I was examining them we explored the fact 10 that, under these sorts of arrangements, it would be 11 wrong but it might be reasonable to think that the 12 bodies that fall under the reserve competence of the 13 Westminster Parliament are, in some way, distant from 14 Scotland and therefore things like setting up offices 15 are actually quite important in making it clear that they have 16 responsibilities in Scotland too? 17 A. That's correct, absolutely. Obviously, you know, with 18 political devolution the nature of those relationships 19 change but the legal responsibilities did not. 20 Q. Indeed, which is an important point to understand. 21 A. Exactly. 22 Q. Other aspects that you tell us were reserved in that way 23 include, you tell us in the report, employment rights 24 and matters pertaining to health and safety law, is that 25 right? Page 73	1 can't just ignore professional regulation or employment 2 law or health and safety matters, all of these things 3 still exist within the operation, it's just that the way 4 in which those things are legislated about and the 5 bodies that are in charge controlling them fall under 6 a different framework; is that correct? 7 A. Yes, certainly and in the context of 8 an employer-employee relationship, questions of 9 occupational health and safety are central aspects of 10 that relationship, contractually and just in terms of on 11 the day-to-day sort of functioning of any sort of 12 organisation, yes. 13 Q. Absolutely, thank you. That's very helpful. So, as far 14 as the Health and Safety Executive is concerned, 15 I wonder, could we look, please, at paragraph 3.14 of 16 the statement. So you've told us here that: 17 "The Health and Safety Executive (HSE) is the 18 UK-wide statutory body responsible for the 19 encouragement, regulation, and enforcement of workplace 20 health, safety, and welfare pursuant to the ... 1974 21 [Act]. As is the case with medical regulation, health 22 and safety law is a reserved matter under current 23 political devolution arrangements, with the HSE acting 24 as the regulatory authority responsible for enforcement 25 matters in order to ensure workplace safety within Page 75
1 A. That's correct. 2 Q. And so therefore, for example, in the same way as the 3 GMC is a body that falls within the reserved competence, 4 so does another body that we've come across in the 5 evidence, called the Health and Safety Executive? 6 A. That's correct and we do note that in the report and 7 their legislation in that regard. There's the legal 8 responsibility, shall we say, set out in legislation but 9 we also note what the practice became in terms of their 10 oversight. 11 Q. Well, you're one step ahead of me because that was 12 exactly what I was wishing to ask you about because this 13 is a matter of some interest. Before we get on to the 14 Health and Safety Executive particularly, which is 15 definitely a matter I'd like to explore with you a bit 16 further, just in terms of employment rights, again, 17 that's a matter that's reserved; is that right? 18 A. Yes. I mean, employment law is not within my area of 19 expertise but just generally. 20 Q. Yes, we won't get into any more detail but these are all 21 aspects that we've come across in evidence that we've 22 looked at, but it's important to understand, as 23 I understand it -- please tell me if I'm wrong -- if 24 a health board is running a hospital, it's not as if 25 it's entitled in some way to ignore these matters. It Page 74	1 Scottish hospitals. Under the [Act], Scottish Health 2 Boards are required to ensure, as far as it is 3 reasonably practicable, the health, safety, and welfare 4 of its staff, which would include their employed 5 doctors. In addition, the Boards are required to 6 ensure, so far as is reasonably practicable, that 7 persons not in their employment (which explicitly 8 includes hospital patients and visitors) are not exposed 9 to risks to their health or safety. 10 "In the relevant period, the HSE's preference was 11 for matters of health and safety to be dealt with via 12 internal disciplinary and enforcement structures within 13 hospitals and/or Health Boards. This was largely on the 14 grounds that it did not, in general, investigate matters 15 of clinical judgement or matters relating directly to 16 the quality of clinical care. Instead, the HSE 17 restricted its interventions in healthcare settings to 18 major 'non-clinical' structural risks impacting staff 19 and patients alike. This included slip/trip hazards, 20 anti-ligature environmental safety in mental healthcare 21 settings, workplace violence, needlestick/sharps 22 injuries, hazardous chemical [exposure], and mechanical 23 failures (such as medical gas or hoist breakdowns). 24 Incidents arising from substandard individual clinical 25 techniques -- such as surgical errors, or poor surgical Page 76

1 decision-making -- were referred to professional 2 regulators (such as the GMC); or healthcare quality 3 improvement bodies, rather than being positioned as 4 criminal breaches of the [Health and Safety at Work 5 Act]." 6 So, various concepts in there which are important to 7 some of the things that we've been looking at. What you 8 tell us is that the strict legal position, as 9 I understand your evidence, is that under the Health and 10 Safety at Work Act, the HSE does have a responsibility, 11 not only for employee health and safety, if I can put it 12 that way, but also for people who come into workplaces 13 and that explicitly, under the Act from a legal 14 perspective, does include patients, is that right? 15 A. Well, again, strictly speaking outside my expertise, but 16 generally as a person with a background in tort law, 17 occupational health and safety and the place of 18 a workplace is something that would -- you know, you 19 would take account of people coming into that space. 20 Q. Yes, but you tell us, however, that it was the HSE's 21 preference not to get involved in such matters. Is that 22 correct? 23 A. I would say, particularly at that time and during a lot 24 of the relevant period, regulators -- I'll call them 25 Health and Safety Executive, but occupational health and Page 77	1 allocation, decision-making rather than strict legal 2 obligation, to devote resources to health and safety at 3 work for employees I think, and that matters were left 4 to the GMC. They would, presumably, also be left to -- 5 for example, in a hospital setting, the health board to 6 regulate on a day-to-day basis is that your 7 understanding? 8 A. I couldn't really comment on what was going on in 9 particular health boards at all. I can talk more 10 generally about regulatory preferences and almost like 11 unintended consequences that result from regulatory 12 regimes and ways in which almost cultural practices 13 arise despite the regulatory frameworks. And that was 14 certainly observed in this period. I would also just 15 turn to my colleagues, Dr Gilder and Professor Walshe, 16 just to check whether they have anything else they'd 17 like to add? Okay, just checking. 18 Q. I think in this area we have to be slightly careful as 19 well because the position, as regards the powers of the 20 Health and Safety Executive in England, legally, is 21 slightly different from in Scotland, so -- 22 A. Yes. 23 Q. -- we have to tread slightly carefully about -- 24 A. (Overspeaking) Yes, I do appreciate that and I'm trying 25 to be as differentiated as I possibly can in the context Page 79
1 safety regulators -- and this is not just confined to 2 Scotland, it was observable in England as well -- is 3 sort of identifying where they would prefer to direct 4 their regulatory resources at the time and liaising with 5 other regulatory bodies by way of referral, say, in 6 professional matters such as involving doctors or other 7 healthcare professionals. And where you intervene with 8 different sorts of law, for example statute and the 9 criminal law. 10 So there was almost a practice, I would say, that 11 grew up in the NHS and the UK generally that 12 occupational health and safety matters would almost come 13 within the remit of the Health and Safety Executive but 14 other matters, such as errors, medical errors, that sort 15 of thing, would be referred off to other regulators such 16 as the GMC. And that is maybe a regulatory preference 17 but also a question of resources available at the time. 18 And particularly when you involve the criminal law 19 in healthcare matters -- and we see it in areas such as 20 medical manslaughter, for example, and -- would be 21 culpable homicide in Scotland -- a marked reluctance to 22 bring criminal prosecutions whether via statute or under 23 existing -- I'm talking about England -- common law. 24 Q. So the position then was that you mentioned that there 25 would be an arrangement, which is based on resource Page 78	1 of complex NHS structures in or around the time of 2 devolution as well. 3 Q. Indeed, that's very helpful to know that that was your 4 understanding of the arrangement. If we could go, 5 please, within the statement to paragraph 3.6. This is 6 where you're telling us about the way in which medical 7 services were run under the legal regime that we've been 8 talking about. It says: 9 "The Scottish Government ministerial team 10 responsible for healthcare are in turn supported at 11 senior management level by the Chief Executive for NHS 12 Scotland and [the] Director-General Health and Social 13 Care, as well as the Chief Medical Officer ... The CMO 14 acts as the senior medical advisor to the Scottish 15 Government, Ministers, and policy teams. The CMO 16 provides a vital clinical voice at the governmental 17 level, issuing professional guidance, setting 18 overarching public health strategy, and maintaining high 19 professional standards across the medical workforce in 20 Scotland." 21 So you've told us before this that the 22 responsibilities were exercised predominantly by the 23 Cabinet Secretary for Health? 24 A. Health and care now. Yes, it's correct. Indeed, since 25 the election -- Page 80

1 Q. (Overspeaking) Social care and sports and things, but 2 broadly, the health -- 3 A. (Overspeaking) And mental health, I believe. 4 Q. But what you're telling us here is that these are the 5 people that would assist the Cabinet Secretary in 6 delivering those services. I was particularly 7 interested in understanding, as far as the structure of 8 executive level decision-making is concerned, what we're 9 dealing with here is the director general, and indeed, 10 I think, the chief executive of NHS Scotland sits within 11 government, and effectively is, as I understand, the 12 person to whom the chief executives of a health board 13 would report, is that right? 14 A. That's right and there's some debate about those sorts 15 of governance arrangements as always part of 16 organisational and other reform, but, yes, during the 17 relevant period. 18 Q. You mentioned there that the chief medical officer's 19 role would be to act as a senior medical advisor and to 20 provide a vital clinical voice. Where do you see -- in 21 the system that exists within Scotland, what's the 22 importance of the chief medical officer in the system? 23 A. Well, it's -- the role of the chief medical officer -- 24 and I'll also bring in my colleagues in this regard -- 25 the role itself, it's interesting. You bring your Page 81	1 Q. But before that, there were other bodies. First of all, 2 the Clinical Standards Board for Scotland from 1999 3 which was superseded by something called the NHS Quality 4 Improvement Scotland from 2003. Now, I think you 5 mentioned this earlier. Was that part of this evolution 6 of creating a different Scottish landscape? 7 A. I think that's right and I would have to say the 8 Scottish -- it was the executive and then the government 9 that it became later on -- it was quite proactive in 10 this space in terms of establishing bodies as well as 11 patient safety programmes in the first decade post 12 political devolution and this was one of those bodies. 13 I mean, it was all wrapped up into Healthcare 14 Improvement Scotland in 2011, but I did want to 15 emphasise there were a range of bodies that really were 16 very strong, I would say, in the first decade post 17 political devolution. 18 Q. Yes, and I think our understanding is that effectively 19 there were a number of bodies that sort of amalgamated 20 at various different stages and then by 2011, you have 21 a full amalgamation into Healthcare Improvement 22 Scotland; is that right? 23 A. That's correct and obviously its remit has expanded as 24 well over time. 25 Q. Yes. We've heard some evidence from Healthcare Page 83
1 medical and/or clinical expertise but you're also 2 a government advisor, so you're wearing a -- very 3 broadly speaking -- two hats in that regard. But 4 particularly, given the political responsibility for 5 NHS Scotland, you know centred in government, the CMO 6 has a vital role to not only bring in the understanding 7 of clinical governance and how things are managed in 8 terms of day-to-day practice, but has an appreciation of 9 higher-level health policy issues. 10 Q. Indeed. Is your understanding that the chief medical 11 officer has a formal role within the formal clinical 12 governance structures? 13 A. Now, that -- I would need to check that. Yes, I don't 14 know -- 15 DR GILDER: I don't know. 16 PROFESSOR FARRELL: No, I would need to check that. 17 Q. Okay, thank you very much. You've told us, also 18 helpfully in your statement, maybe one of the things 19 that you were referring to earlier about the way in 20 which the landscape changed after devolution, you've 21 told us about a number of bodies that were involved in 22 Scotland in, broadly, healthcare improvement. And there 23 was a body that came about in 2011, with -- pre- sort of 24 Healthcare Improvement Scotland came about in 2011? 25 A. Indeed, yes. Page 82	1 Improvement Scotland about what they do, but one aspect 2 which it might benefit for the input of someone with 3 more an English experience but your own experience, 4 Professor Farrell, is that one aspect of Healthcare 5 Improvement Scotland is that although its powers appear 6 to have grown over time, for example involving the 7 ability to undertake investigations in situations where 8 there might be healthcare improvement aspects in 9 a service which needing to be looked at, it is not 10 a regulator in the public sphere -- 11 A. Yes. 12 Q. -- unlike, as I understand it, the Care Quality 13 Commission in England. And I was interested in 14 understanding -- our understanding of the situation is 15 effectively the regulator, in the public sphere, not in 16 the private sphere but in the public sphere, is 17 effectively the government? 18 A. It is. 19 Q. That appears to be a difference from the English system 20 and I wondered, given the importance to this Inquiry and 21 more broadly of healthcare improvement, whether that's 22 something on which you had reflections? I'm opening 23 that out to everybody. I suppose the question is around 24 how important is it that there be a regulatory body for 25 public healthcare services? Page 84

1 A. Okay, I'm going to defer. I will add some comments, but 2 I'd like to defer initially to Dr Gilder and 3 Professor Walshe. 4 PROFESSOR WALSH: There's a slightly bewildering set of 5 initials and names for a variety of bodies, both in 6 England and in Scotland over this period, dealing with 7 the inspection and/or regulation of health and social 8 care, in both public and private sectors. So trying to 9 make sense of it is not always straightforward. 10 THE CHAIR: I'm glad you made that point, Professor, because 11 there's a lot of names to digest. 12 PROFESSOR WALSH: There is. Pre-devolution, pre-1999 or 13 so, for a long time the attitude, certainly of the 14 Department of Health in England and I think also of the 15 Scottish Office, was that they didn't need 16 an inspectorate, that, you know, actually the department 17 was well-positioned to undertake the necessary 18 performance management of health authorities and health 19 boards and other healthcare bodies. 20 That did change, as a result largely of the Bristol 21 Inquiry to which we've already referred, and that saw 22 the creation in England of the Commission for Health 23 Improvement and in Scotland of Quality Improvement 24 Scotland. And over time, those bodies got renamed and 25 they, broadly speaking, got amalgamated. I'd say there Page 85	1 Whereas in the NHS, the Secretary of State or the 2 Scottish Government has all those powers of direction 3 over health boards and trusts, through which it can, if 4 it wishes to, enact the decisions of Healthcare 5 Improvement Scotland. So I'm not sure that the two are 6 really as different as they might appear. I'm not sure 7 if that helps? 8 Q. No, that's very helpful indeed because from the outside 9 it might look like that's quite a significant difference 10 but what you're telling us is your experience is that 11 might be slightly illusory; is that correct? 12 A. To some degree and I would say that for government in 13 England, actually having the quasi-independence of the 14 Care Quality Commission, as it is now, has often been 15 an advantage in the NHS setting because it allows 16 government, to some degree, to distance itself from 17 sometimes quite difficult matters of operation on 18 delivery and say: no, no, that is the business of our 19 regulator, the Care Quality Commission, which will 20 undertake inspections and enforcement actions and so on. 21 And it can be helpful for government to be at some 22 distance from the enacting of those decisions. I think 23 that's one reason why government in England has chosen 24 to have the CQC in that role. It's then less directly, 25 if you like, a hotline to the Secretary of State as the Page 87
1 are two main amalgamations there, so in both England and 2 in Scotland, separate bodies were set up to regulate NHS 3 or public healthcare services and private healthcare 4 services, private hospitals and clinics, and those came 5 together. 6 And in both cases, separate bodies were set up to 7 regulate social care and healthcare and in England, 8 after quite a few variations of reforms, that came 9 together in the Care Quality Commission. The Care 10 Quality Commission does have formal regulatory powers 11 which are broadly similar over both NHS public bodies 12 and private bodies and it has a relatively consistent 13 regulatory regime, for example, for private hospitals 14 and for NHS-operated hospitals. 15 In practice, the Department of Health continues to 16 have extensive powers of direction over the Care Quality 17 Commission. So while it is an independent regulator, it 18 still does the bidding, essentially, of the Department 19 of Health in both areas. 20 So, I think it may be a bit of a distinction without 21 a difference to talk about Healthcare Improvement 22 Scotland not regulating in the healthcare sector but 23 regulating in the private sector because clearly, in the 24 private sector, the regulator needs some statutory 25 powers in order to exert enforcement, for example. Page 86	1 responsible person in government. 2 Q. Even within the limitations, if I can put it that way, 3 of what Healthcare Improvement Scotland can do, would 4 you consider it an important feature of the healthcare 5 improvement system landscape in Scotland, or perhaps 6 more wider in the UK, that the facilities of a body like 7 that are used in circumstances where there are issues 8 relating to healthcare? 9 A. So I think much more in England than in Scotland because 10 we've had a number of reforms of CQC and its 11 predecessors initiated because of concerns about how 12 effective they've been in overseeing the quality of 13 services, both in the NHS and in the independent sector. 14 There has been much debate about their effectiveness. 15 But I would say that those regulators have been a really 16 important backstop which didn't exist pre-1999 or 2000, 17 providing government with a way of tackling, 18 investigating and seeking to change, particularly 19 serious quality problems in healthcare bodies, but also 20 for patients, communities, the population, the media and 21 other interested stakeholders in having some assurance 22 that there's somebody policing the system, producing 23 independent inspection reports, publishing those 24 reports, and acting on behalf of patients in the way 25 that regulators in other sectors, be it in civil Page 88

1 aviation, or public health or whatever, exist to provide 2 protection for the public. 3 Q. Okay. We heard some evidence -- it now seems like 4 a long time ago -- in the first week of our sessions, 5 from the Patient Safety Commissioner for Scotland. She 6 performs a particular statutory function to do with 7 patient advocacy and promoting the interests and rights 8 of patients throughout the system. She's the first 9 holder of the role and has been in the position for 10 about a year. And she has been, over that year, setting 11 up her office and she has been starting to engage with 12 patient safety-related issues that she's able to detect 13 across the system. Her role is a systemic role rather 14 than an individual advocacy role. 15 And I asked her about some of her reflections on 16 that year as what she felt that she saw within the 17 system and one aspect, certainly as I understood her 18 evidence, was that she felt that there were a lot of 19 bodies in the Scottish healthcare improvement system who 20 are very good with coming up with ideas about healthcare 21 improvement, very expert, but there perhaps wasn't 22 enough emphasis on actually effecting that improvement. 23 So there were lots of good ideas, lots of good people 24 who know what they're doing, but there may be an issue 25 in actually carrying that through. Page 89	1 those recommendations have statutory force or are 2 mandatory would be really helpful. And the same 3 phenomena of having, in England the healthcare safety 4 investigation body, a patient safety commissioner, the 5 Care Quality Commission, Royal Colleges and others all 6 undertaking reviews, making recommendations and 7 healthcare organisations being faced by this deluge of 8 suggested improvements. 9 Q. I was going to say barrage. 10 A. "Barrage" is a good word too. 11 Q. I suppose then, rather than looking at the 12 Scottish-specific situation, those would be important 13 general principles and lessons to learn about perhaps 14 how the system might function better based on the 15 English experience, is that right? 16 A. Yes and there are always cause for simplification but 17 you also have to point out that the healthcare 18 organisations are really big, complex, multi-service 19 organisations. So the idea that you can have one system 20 that works for an organisation that delivers a variety 21 of primary, secondary and tertiary healthcare services 22 and regulates everything from radiation safety to the 23 quality of care in care homes, you know, you have to 24 recognise regulation is complex, because the 25 organisations are complex. Page 91
1 Now, of course she's looking at things from 2 a patient safety perspective, but one would like to 3 think that everyone is looking at things from a patient 4 safety perspective. Is that a feature of your 5 understanding of the Scottish system insofar as you've 6 looked at it, Professor Walshe? 7 A. I have to be clear in saying I think my expertise in the 8 Scottish system is much less strong than my expertise in 9 England. 10 Q. Well, perhaps more generally, is that a danger? 11 A. Speaking more generally, in fact last year or the year 12 before, Penny Dash did a review of the patient safety 13 landscape in England and recommended a series of changes 14 designed really to make it simpler. What she says was 15 there was a profusion of different bodies, all with 16 slightly different responsibilities, all providing, to 17 some degree, oversight of issues of safety and quality 18 and that for healthcare organisations and also for 19 professionals, there was a kind of thicket of 20 recommendations and proposals and that they were 21 somewhat overwhelmed by the number of people suggesting 22 things they could do to improve patient safety. 23 So I think you're hinting that, you know, 24 simplification of that structure and clarity in that 25 structure about who makes recommendations, and which of Page 90	1 Q. I think, in that, there might actually be an important 2 lesson because obviously we are looking at things with 3 quite a narrow focus at times. We're particularly 4 interested in surgery or neurosurgery. But it is 5 important to understand that, for example, health boards 6 and executives of health boards are responsible for very 7 much more and a wider range of services, as we've seen 8 through the 1978 Act, than just neurosurgery or surgery. 9 Is that an important thing to understand in the system? 10 A. Yes, I'm sure it is. 11 Q. Thank you. 12 THE CHAIR: Could I just, professor, I didn't note the name 13 of the individual who conducted the review to which you 14 just made reference? 15 PROFESSOR WALSHE: I referred to Penny Dash, who is the 16 Chair of NHS England and who undertook a review last 17 year -- was it last year or the year before? 2025 or 18 2024? 19 DR GILDER: 2024. 20 THE CHAIR: We could probably find it with that information. 21 Thank you. 22 MR DAWSON: Thank you, sir. To go back to the report and 23 I think again, text inserted by Professor Farrell, 24 there's one aspect -- I think, again, you mention this 25 in your narrative at paragraph 3.18, please. This is Page 92

1 the sort of landmarks, if you like, in the development 2 of the healthcare system in the post-devolution world. 3 You tell us about certain important developments, 4 I think in 2007: 5 "In terms of a focus on driving quality improvements 6 to enhance patient safety, the Scottish Patient Safety 7 Programme ... was established in 2007 in order to 8 promote patient safety initiatives in Scotland, as well 9 as to address the problem of avoidable events causing 10 harm to patients in healthcare settings. It represented 11 the first time that a national quality improvement 12 programme had been established to facilitate the safer 13 delivery of healthcare in the UK context. Following on 14 from its establishment in 2011 HIS also relied on the 15 SPSP in its work to drive quality improvement in 16 healthcare in Scotland." 17 I think you maybe mentioned that earlier, 18 Professor Farrell. Could you tell us, do you know 19 anything a bit more about that particular programme and 20 why it was important in the period that we're looking 21 at? 22 A. Well, I think, as Professor Walshe has pointed out, 23 there's been an evolution in thinking around quality 24 improvement and patient safety within the NHS in the UK 25 generally. So a commitment, on the part of a devolved Page 93	1 Patient Rights and Responsibilities, which I think flows 2 from it -- 3 A. (Overspeaking) Which is what the Act enacted and it's 4 been updated as well over time. I mean, recognising 5 rights and responsibilities that are a part of existing 6 law but that recognition was important. I was part of 7 the no fault compensation review that the Scottish 8 Government conducted in 2009, 2010 doing research for it 9 and we looked at all these initiatives as well as in 10 terms of trying to adopt a more patient-centred focus in 11 health policy initiatives in Scotland, of which that was 12 one. 13 Q. In the same way as we saw with the ethics group, would 14 it be wrong to look at the enactment of the 2011 Act as 15 sort of a moment in time when, from now on there are 16 patient rights? Would it be better to look at it as 17 a culmination of a process that had existed for a long 18 time but now was being enshrined in law? 19 A. I think that is a fair summary of that and what we also 20 need to take account of is that, in the context of 21 political devolution of the government sort of putting 22 a recognition of patient rights -- for example, if you 23 look in England you've got the NHS constitution, which 24 sets out a lot of those rights. So in terms of 25 an initiative of a devolved nation government, it was Page 95
1 nation, to developing an explicit patient safety 2 programme -- I mean, I pointed out in paragraph 3.19 as 3 well, across a range of areas, not seeing it in that 4 siloed way. Now obviously cultural change in that 5 regard can take time and it was part of a suite of 6 packages that, for example, the Scottish Patient Safety 7 Alliance, which I refer to, was involved in implementing 8 and that aligned with the legislation in 2011 for 9 patients' rights and responsibilities as well. 10 So it's all part of a package and it was seen more 11 broadly in policy terms and then to be operationalised, 12 of course, by health boards. 13 Q. As you say, perhaps in accordance with the process that 14 we talked about with the ethics group and things 15 developing into legal enactments or legal rules, this 16 programme, I think you tell us, develops into the Act in 17 2011, the Patient Rights (Scotland) Act -- 18 A. (Overspeaking) Part of it. Obviously quality 19 improvement is more broad than patient rights and 20 responsibilities but in researching this area and 21 understanding it, certainly one got a sense that the 22 Scottish Government was engaged in enacting a series of 23 measures to set out its patient safety programme, of 24 which that legislation in 2011 was one. 25 Q. And I think you also tell us about the Charter of Page 94	1 part of a suite of measures that were, as I've mentioned 2 previously, developed and adopted in that first decade 3 following political devolution. 4 Q. Can we look, please, at ELJ0003-00013. This is 5 an extract from the patient rights and responsibilities 6 charter that you tell us about in the statement which 7 was published in 2012. If we scroll through to page 2, 8 please. This sets out there some of the rights that 9 were enshrined, as you've told us, within the charter at 10 that time in the aftermath of the 2011 Act: 11 "Access: your rights when using health services. 12 "Confidentiality: the right for your personal health 13 information to be kept secure and confidential. 14 "Communication and participation: the right to be 15 informed, and involved in decisions, about health care 16 and services. 17 "Respect: the right to be treated with dignity and 18 respect. 19 "Safety: the right to safe and effective care. 20 "Comments and complaints: the right to have a say 21 about your care and have any concerns dealt with, and 22 what you can do if you feel your rights have not been 23 respected." 24 It goes on to tell us various other aspects, but 25 just to be clear on this, these are all things which Page 96

1 existed within the healthcare provision before, is that 2 right? 3 A. Exactly, and in fact, the adoption of the legislation 4 that implemented, or you know, enabled the charter to be 5 created. They were very clear that it came from 6 existing rights and obligations, it was not creating 7 something new, yes, so that was made clear. 8 Q. Do you think that it would be accurate to reflect the 9 Act in the charter as being the result -- because 10 obviously governments make choices about what to spend 11 legislative time looking at what they want to prioritise 12 as political priorities. Would it be correct to 13 interpret these things being stated so categorically at 14 this period as a recognition that although these facets 15 of the system had existed for a long time before this, 16 that there needed to be clarity, perhaps because the 17 government was of the view that these things were not 18 focused on enough in healthcare provision? 19 A. I think that's an element of it. I would also say, in 20 the context of political devolution and the need to mark 21 a distinctive Scottish approach to health and 22 NHS Scotland, given that so much of its budget and so 23 much of its political capital was around the health -- 24 the provision of health services in the system as well, 25 that it was dealing with a range of aspects of the Page 97	1 the Inquiry is obviously interested in and you've helped 2 us with -- and we'll come to it in more detail -- but 3 the right to have a say about your care and have any 4 concerns dealt with and be informed as to what you can 5 do if you feel your rights have not been respected, 6 would it be fair to look at that as something which 7 ought to have been a feature for some time before that? 8 A. And again, it has -- I mean, complaint systems have long 9 been a feature of the NHS more generally in the UK and 10 it was recognised, through successive reforms, that more 11 was needed. And I know I do mention this in the various 12 sections of the report and I'm happy to go to it as 13 well, but also what you do with patient complaint data 14 and how you link that into patient safety and notions 15 harm, there was a much greater appreciation of that 16 importance of that on a UK-wide basis that even preceded 17 this legislation and charter. 18 Q. Yes, indeed. Again, referring back to some evidence we 19 heard from the Patient Safety Commissioner for Scotland, 20 one of the aspects we looked at with her in her 21 year-long -- trying to get used to the Scottish system, 22 was complaints and the way that they are dealt with. 23 And we discussed what barriers to complaints, or 24 successful complaint systems might be. And she focused 25 very much on the difficulty of accessibility of Page 99
1 health system and this was certainly a predominant 2 element and a range of quality and safety initiatives, 3 as well as what happens to patients when they suffer 4 harm in the health system. They were a part of a raft 5 of initiatives that were considered by the Scottish 6 Government during this period. 7 Q. But when one looks at this, or indeed other things that 8 we've mentioned, for example the duty of candour or 9 other things that become law, especially when they 10 involve legislation, would it be correct to look at that 11 sort of evolution as a system in which the government 12 reaches a point where it feels: this is something that 13 we really need to focus on in order to try to make it 14 clear, to healthcare providers for example, that these 15 things need to be taken seriously, they are important 16 features of a modern, effective healthcare system? 17 A. I think that was certainly the way it was presented at 18 the time. Obviously I don't have a bird's-eye view into 19 the thinking of the ministers at the time, but as 20 a policy initiative it was very prominent. 21 Q. Because if you take for example -- 22 A. Legislative, sorry. 23 Q. Thank you. If you take, for example, one aspect of the 24 legislative regime in the charter that I've mentioned 25 there, the comments and complaints, this is an area that Page 98	1 complaint systems for some people. And indeed her 2 evidence, as I understood it, was that sometimes the 3 people that find it hardest to access systems, who have 4 the highest accessibility issues, are the very people 5 that need to rely on the complaints or concerns systems? 6 A. That is certainly the case actually in empirical 7 research across a range of health systems. One of the 8 areas in which a lot of data has been collected, for 9 example, is in the New Zealand no fault system, 10 involving accidental injury including medical accidental 11 injury. And what they discovered, through the 12 collection of data, was that those who were most 13 marginalised or minoritised communities within the 14 health system were least able to navigate complaint 15 systems and that further work needed to be done to 16 ensure that they were able to access it, that they were 17 supported, that they had advocates that could help them 18 navigate that process. 19 Obviously, in the Scottish system various ways have 20 been implemented to facilitate that but again, also 21 empirical research in the Scottish context -- and that 22 is referred to in our report -- talking about the 23 difficulties that patients and families did experience, 24 even in the relevant period, with not only accessing 25 complaints systems but navigating how best to discuss Page 100

1 problems they had in relation to the treatment they 2 received. 3 Q. Well, again, this is precisely what I was interested in 4 focusing in on because you do tell us in the report, 5 that there was evidence to suggest that although 6 complaints systems existed, they perhaps had -- they 7 were defective, in various different ways in which 8 you've set out. And what I'm trying to understand is 9 perhaps, by 2011, this is a point where, by 10 incorporating this into its legislation, the Scottish 11 Parliament ultimately is saying: this is an important 12 part of a system that needs to be given greater 13 prominence because without a mature system of feedback, 14 complaints, concerns, that is a fundamental flaw in 15 a proper healthcare system. Would that be a correct 16 interpretation? 17 A. Well, I can speak from my own experience of, for example 18 one of the pieces of empirical research I refer to, 19 I think it's the Krauss et al study, that arose out of 20 a group of us doing commissioned research for the 21 no-fault compensation review in 2009 to 2010 and that 22 involved speaking to patients about their experiences of 23 navigating complaints or suffering harm within 24 NHS Scotland. And as I highlight in the report, it 25 proved to be a mixture of issues but things such as -- Page 101	1 a no-fault system benefit in terms of the gathering of 2 that data? Often the -- well, the data we did gather 3 too said consulting lawyers was probably the last resort 4 in terms of trying to navigate a system and when that 5 didn't work -- apologies to all lawyers, having been one 6 in practice, myself -- but it was something that 7 patients and their families did not take lightly but 8 they wished for better communication with their -- and 9 understanding of what had happened to them in the 10 healthcare system. And that relationship with the 11 doctors and the healthcare professionals to obtain that 12 information was vital. 13 Q. Thank you. And so just to be clear, in looking at the 14 idea that we might have no-fault compensation, you were 15 trying to understand the context -- 16 A. The broader -- sorry to interrupt you, sorry. Just the 17 broader context in which it happens. I mean, clinical 18 negligence or medical negligence claims are a symptom or 19 a sign that alleged harm has been caused to patients in 20 a healthcare system, but I would go back to 21 Sir Liam Donaldson's report in 2003 "Making Amends", 22 although he was based in England, that recognition that 23 there are various elements that make up safety in 24 a healthcare system for which you may seek redress and 25 the need to join up all these forms of data, whether Page 103
1 all of the things listed actually in the charter, but 2 particularly miscommunication, not being -- feeling 3 listened to or respected but also just navigating the 4 system. And particularly communication with their 5 treating healthcare professionals and around disclosure 6 of information and risks associated with their treatment 7 and follow-through when things may have gone wrong, 8 I'm not saying it was inadvertent or negligent or 9 whatever, but being able to maintain that dialogue with 10 their treating healthcare professionals was absolutely 11 vital and there were quite pronounced difficulties 12 identified in the empirical research that was gathered 13 for that report and then was published in academic 14 research. 15 Q. Thank you. Just to understand, you were looking at that 16 in the context of no-fault compensation, is that right? 17 A. That's correct but obviously, when you're looking at a 18 no-fault compensation system -- and we were looking at 19 what was going on in the Nordic countries as well as in 20 New Zealand in particular -- the way in which you share 21 data around events that highlight harm taking place in 22 systems, you would look to patient safety data, you 23 would look to complaints data, in terms of injury and 24 harm, and then making decision whether you would want to 25 then take legal action in that regard. So what would Page 102	1 it's patient safety, whether it's legal claims, whether 2 it's sentinel events, for example, or adverse event 3 monitoring in healthcare systems, there's a need for 4 a joined-up approach, if you're going to effectively 5 implement both patient-centred care -- although that 6 wasn't the term used in 2003 -- but also redress. 7 Q. We've heard a term in other evidence which I think is 8 the concept you're talking about of bringing together 9 different data sets which might indicate that something 10 is going wrong in the system. The word that was used 11 was "triangulation" in data. 12 A. Yes, and Dr Gilder has also contributed to that in the 13 report and could comment more broadly on that, I would 14 suggest, in relation to health systems more generally. 15 DR GILDER: Yes. I think the answer to that is "yes". And 16 certainly now, we pool our -- as part of clinical 17 governance, you pool everything together. You have 18 pooled data, you use -- many organisations would use 19 Datix which would include risks, would include adverse 20 events, would include sentinel events, would include 21 never events, would include morbidity and mortality, 22 would include legal complaints and does include 23 complaints -- patients' complaints as well. 24 Q. Yes, the Datix system is something we've come across. 25 It's a computer system, isn't that right? Page 104

1 A. Yes, it's just a big database which you can categorise 2 and search in and report on. 3 Q. Is that a system that you're familiar with from your own 4 practice? 5 A. Yes. 6 Q. And when -- over what sort of time period was that first 7 used? 8 A. I don't remember when it started, but certainly from the 9 last 15, 20 years, something like that? 10 PROFESSOR WALSH: I would say it's been around for at least 11 20 years. We could confirm exactly when, but that idea 12 of having a computer system that you put incident 13 reports onto and which you then mine and interrogate and 14 share with other organisations has been around for 15 two decades. 16 Q. Right. We've heard some evidence about its use but also 17 the fact that, prior to its introduction within Tayside 18 at least, there were other systems that were in use that 19 were more fragmented, I think it would be fair to say? 20 DR GILDER: That's right, they were not joined up. So you 21 a patient complaint, you'd have a patient complaint, 22 people who did it. You'd have your quality of care, 23 your patient safety team and also quite a lot of it 24 would have been kept on sort of paper, or Excel 25 spreadsheets. Page 105	1 I mean, you need a culture to improve reporting, in 2 terms of -- I'm sure you've discussed things like a just 3 culture, a no-blame culture, but it's part of how we 4 improve the reporting of incidents, near misses, 5 everything. And what Datix did was bring risk 6 management in, enable the risks element to be brought in 7 to one place, patient complaints to be brought into one 8 place. So you would look across a whole spectrum of 9 ways in which we could understand what is happening with 10 the quality of care of our patients because obviously 11 the triangulation is multiple different sources. 12 Q. Understood. So then, just to be clear on this -- 13 because this is important to us -- there are two at 14 least two advantages of that system. One is that when 15 one is busy in a hospital with lots of things going on, 16 it's important that the important information is fed 17 into the system? 18 A. Yes. 19 Q. And that you're talking about the reporting, using the 20 computer system made it easier to do that, is that 21 right? 22 A. In real time, which is critical. 23 Q. In real time, and therefore perhaps making it more 24 accurate as what's being put in, is that right? 25 A. Yes, higher quality data. Page 107
1 Q. As I understand it, Datix is mentioned, I think maybe in 2 some of the stuff that you told us in the report, 3 Professor Walshe, but it's particularly interesting 4 I think to understand that so Datix, let's say it was 5 coming in around 20 years ago, so 2005, 2006, something 6 like that? Would that be fair, roughly? 7 PROFESSOR WALSH: I'd want to just confirm a date. 8 Q. Absolutely, but that's your feel for it. But 9 presumably, what that must have meant, as I understand 10 the nature of the system is to bring together lots of 11 systems to, as Professor Farrell said, triangulate the 12 data in order to be able to make the best decisions 13 about what needs to be done to improve healthcare, as 14 I understand it. Is it the case then, at the time when 15 Datix was being introduced, whatever precisely that was, 16 around 20 years ago, that the value of triangulating the 17 data, if I'm using the term correctly, was appreciated 18 and that's why that system, that computer system was 19 developed, is that right? 20 DR GILDER: Yes, but another reason was to make it easier to 21 report. So when that came in, it was much easier for us 22 to just fill in a thing, fill in a form on a computer. 23 So when things happened -- and not just report, but then 24 it was easier for the organisation to follow up on and 25 see what was going on. But it certainly improved -- Page 106	1 Q. And then beyond that, once all of that good quality data 2 has hopefully been input by the busy professionals, then 3 the ability to triangulate that data and make good, 4 evidence-based decisions is the overall objective of 5 bringing these different systems together, is that 6 right? 7 A. Yes. 8 MR DAWSON: Excellent, that's very helpful indeed. Thank 9 you. 10 Sir, that would be a convenient moment for a lunch 11 break. 12 THE CHAIR: All right. We'll take an hour for lunch now and 13 we'll sit again at 1.45. 14 (12.45 pm) 15 (The short adjournment) 16 (1.46 pm) 17 THE CHAIR: Good afternoon. I think we're now ready to 18 resume. Mr Dawson. 19 MR DAWSON: Thank you very much. 20 Before we move on to a separate section, there's 21 a point I want to pick up with Dr Gilder, if that's 22 okay. We were discussing before the lunch break 23 important components of systems that might have been 24 improved by Datix coming along, in particular the 25 ability to maximise someone, a clinician, for example, Page 108

1 ability to input into the system -- input 2 contemporaneously, in particular you told us, but also 3 the resultant ability for all of the data and 4 intelligence within the system to be triangulated and 5 therefore form a good basis for decision-making. 6 One aspect of that which is certainly of interest to 7 the Inquiry is the extent to which one can have a lot of 8 systems, one can have policies, one can have computer 9 systems, but is it important in an effective healthcare 10 system that there be a sophisticated level of audit, 11 that people are actually using and complying with the 12 systems on the ground? 13 DR GILDER: Very much so and the national quality audits are 14 a really good example of that actually, they make 15 a difference to healthcare. So there's the national 16 diabetes audit. The national registries are another -- 17 and there's a bone registry, spinal registry, which has 18 been referred to. So yes, it's very important. 19 There's one thing I wanted to add to the Datix 20 comment and that is that the drawback of Datix, using 21 Datix as a national way of collecting data, the drawback 22 is that every organisation can customise their own 23 fields which means pulling -- aggregating the data to 24 look for broader trends is actually quite difficult. 25 Sorry, the other national quality audit, the really Page 109	1 complaints-related information, if, within a hospital, 2 one doesn't have a system for trying to ensure that 3 people are using that system, using it properly, 4 there's really not a lot of point of having policies and 5 systems because they're not going to have the effect 6 that one desires; is that correct? 7 A. No, you need to create a culture whereby if you put in 8 an incident report, you are told what the outcome is. 9 You need a system that's -- people are employed who are 10 skilled in analysis of data, who are skilled in 11 undertaking an investigation, and who are given the 12 time -- and you need a system where clinicians are able 13 to input and are given time to actually spend on these 14 investigations. So the organisation actually has to 15 invest in people's time and skills in order for these to 16 be meaningful. 17 Clinicians will do things, will participate in 18 things such as these if they're meaningful and they 19 change outcome but if, as has happened to me, I have put 20 in something that I thought was very important, clearly, 21 and I got no response, or I got noted, then it just 22 totally disincentivises you to actually report. 23 Q. And is it, based on -- you've got a wide experience of 24 working as a consultant yourself, you've mentioned 25 working with lots of surgeons but also a responsible Page 111
1 good one is the neurosurgical -- the stroke audit is 2 excellent. So yes, and they're very powerful 3 influencers and we would -- in the organisations in 4 which I worked, we absolutely used them and held our 5 services to account if there were areas where clearly we 6 needed to improve. 7 And because you're aggregating quite a lot large 8 amount of data and these are quite sophisticated 9 approaches to audit and particularly statistical 10 analysis and if you're looking at smaller numbers, which 11 in neurosurgery, you are -- I'm very familiar with 12 transplant outcomes, liver transplant outcomes, I do 13 a lot of liver transplants -- and so the organ -- the 14 different -- there's the eight hospitals, they're all 15 compared across a dataset held by NHS blood and 16 transplant, which shows you where you need to look. 17 Q. But what I mean by that -- that's helpful, but I mean 18 "audit" in a more generalised sense, rather than the 19 medical audit sense or the sort of outcomes that 20 might -- you might be comparing in the context you are 21 talking about. What I mean is when you have systems, 22 say in a hospital, which are designed to try to maximise 23 and promote people, inputting contemporaneous 24 information into that, perhaps things that have gone 25 wrong, and to aggregate that information with effective Page 110	1 officer, medical director, looking at the way that 2 doctors are conducting themselves. Is it your 3 experience that, as I think you've alluded to yourself, 4 that if the systems aren't effective enough in 5 effectively attracting people to making them usable, 6 making them attractive that people can use them, that 7 people simply will not? 8 A. Correct. 9 Q. And what's the result of that for the efficiency of the 10 system that we'd be trying to promote? 11 A. I'm not sure it's about efficiency, it's about quality 12 of care of patients. 13 Q. And how is that affected? 14 A. Well, the quality does not improve, you do not learn, 15 you may miss sentinel events, you may not have -- near 16 misses are very helpful in terms of data analysis in 17 picking up things that, you know, you don't learn -- you 18 don't put systems in place to prevent further harm or 19 harm from occurring in the first place. And you also 20 don't understand organisation -- what the risk is, you 21 don't pick up risk if people aren't reporting. 22 Q. Because near misses, as I think someone reflects in the 23 report, are about trying to learn in a preventative 24 sense, aren't they? 25 A. Correct. So I nearly gave the wrong drug because two Page 112

1 ampules look the same. That's a really important -- so 2 hydrocortisone, a powerful drug that puts your blood 3 pressure up came in the same size, same shape, same 4 ampule and I, thankfully, was going to draw the wrong 5 one up and didn't. You know, so you report those 6 things, so that one ampule is redesigned. I mean, 7 there's other systems like two-person check. 8 Anaesthetists don't have two-person check, we tend to 9 draw up all our own drugs by ourselves and only check 10 controlled drugs; that's the way we do things. So 11 you're vulnerable to when -- but that's a near miss -- 12 it's a really good example of a near miss, which you'd 13 need to report because things will change as 14 a consequence. 15 Q. That's very helpful, thank you. So, building on that, 16 I'm going to now move away from the area of looking at 17 the landscape that Professor Farrell was helping us with 18 and we'll move to a section I think Professor Walshe was 19 responsible for, which was in response to question 4. 20 You set out for us a number of principles that you 21 thought were important in the way that healthcare 22 systems should work and you set out for us there 23 a number of things, including the fact that, at 4.1, if 24 we can just get that up on the screen, please. You told 25 us that, as you have already to a certain extent, Page 113	1 a degree of executive responsibility for what doctors 2 were doing in hospitals. I wonder if you could help us 3 understand that a little bit more fully? 4 PROFESSOR WALSH: It's a very broad question so 5 I'll perhaps give with a short answer and you can tell 6 me -- 7 Q. Yes. 8 A. So I think over that period, again, in no small measure 9 as a consequence of the Bristol Royal Infirmary affair 10 and the report by Sir Ian Kennedy as a result of that 11 public inquiry, over that period I think there was 12 a real conceptual shift and a shift in the profession 13 because the profession, I think, was horrified by what 14 had happened in Bristol. And it was constantly in the 15 British Medical Journal, the GMC tribunal was chaired by 16 the then president of the GMC, Sir Donald Irvine, the 17 tribunal that then struck off two of the three doctors 18 involved. So it was so front and centre in people's 19 thinking that it drove some very important changes. 20 Changes in professional regulation, which I can 21 speak more about if you like, the way the GMC worked, 22 its statutory powers, and indeed the governance of the 23 GMC. But also changes in thinking about organisational 24 regulation and the introduction of a system for 25 oversight of organisations, the Commission for Health Page 115
1 focusing on the time period: 2 "During the relevant period, the development of 3 principles promoting patient safety treatment and care 4 came predominantly within the remit of peer regulation 5 of doctors. This was particularly the case in the 6 1990s ... This began to change as a result of a series 7 of healthcare scandals ... as well as a growing 8 appreciation of the need for a more systematic, 9 organisation-wide approach. This was underpinned by 10 regulatory frameworks that were designed to guarantee 11 standards of care and manage clinical risk ... as well 12 as to facilitate greater corporate accountability on the 13 part of NHS Health Trusts/Boards, including in Scotland. 14 Specifically, in the relevant period, key principles 15 governing policy-making, decision-making and delivery of 16 services in the NHS in relation to patient safety, 17 treatment and care in high-risk specialties, such as 18 neurosurgery, should have had ..." 19 Then you list a number of factors. So just reflect 20 on that for a moment. A number of interesting aspects 21 that I'd just like to explore a little bit with you. 22 First of all, you tell us that there was 23 an important aspect of this relating to the peer 24 regulation of doctors and what, as I understand it, was 25 an increasing realisation that there needed to be Page 114	1 Improvement, but also this idea of clinical governance. 2 And I wouldn't underestimate how powerful that idea was 3 because it was trying to bring together ideas about both 4 professional and organisational governance and 5 regulation and to say these things should be integrated, 6 and that, as an organisation, a healthcare provider 7 should have corporate accountability for clinical 8 performance. 9 And that may seem an obvious thing to say but at the 10 time that was a real shift in people's thinking from 11 a period not that long before then when we regarded 12 clinical practice as the concern almost exclusively of 13 doctors and their peers. And if you were a manager -- 14 and I was an NHS manager in the 1980s -- you had no 15 involvement in meetings or discussions or concerns about 16 the clinical practice of your clinicians. They would 17 have mortality and morbidity meetings but often, those 18 would just be attended by doctors. Might let some 19 nurses in. Managers did not go. 20 So it's a cultural shift that was really important 21 and really happened around that period around the 22 Bristol Royal Infirmary Inquiry. 23 Q. Understood, that's very helpful. So again, as I've 24 heard there are a number of important concepts there. 25 I'd quite like to spend a bit of time dwelling on the Page 116

1 issues relating to the Bristol Inquiry because it's been 2 mentioned to us by many, many witnesses in different 3 contexts as we've gone through, who have been reflecting 4 on these changes, either from an expert perspective or 5 a practical perspective in their own experience. Just 6 to get the timescales again. The Inquiry reported, 7 I think, in 2001, is that right? 8 A. Yes. 9 Q. And so therefore, as a result of that, certain changes 10 happened after the report; is that correct, broadly? 11 A. Yes, but the way Sir Ian Kennedy ran his Inquiry, 12 I think, was designed to make it have an impact as it 13 went along as well as in the report. He didn't produce 14 phased Inquiry reports but he did split it into stages. 15 And I think you could see the footprint of the BRI 16 scandal and the GMC investigation in the policy 17 documents like the new NHS modern independent, which 18 I think came out in 1998, but pre-figured a lot of the 19 recommendations in the Inquiry. 20 Q. And indeed, we've already spoken, I think, about the 21 fact that -- in the context of devolution, about the 22 fact that there was an important document -- we may come 23 to it in due course -- relating to the introduction of 24 clinical governance that had come before the report. In 25 particular, one that Professor Farrell told us straddled Page 117	1 happening, what the thinking was. And therefore, would 2 it be fair to say, although as you've helpfully pointed 3 out one doesn't see the report come out and then things 4 happen thereafter, it was a continuum based on which the 5 Inquiry was run, the way in which evidence and 6 information about the scandal emerged. But it's 7 important I think to understand, to try to contextualise 8 things, that the sorts of things that were happening 9 during or in the aftermath of the Bristol Inquiry were 10 the sorts of things that should have been affecting 11 practice in the relevant period, would that be fair? 12 A. And did affect practice in the relevant period, yes. 13 Q. Yes, but insofar as it didn't, it should have been? 14 A. Might have to clarify what -- 15 Q. Yes, if there were evidence that it had not affected 16 practice and it had not been taken into account, that 17 would be something that should have been taken into 18 account. You told me it did affect practice, doctors 19 did start behaving differently. But if some others 20 didn't, is it the position they should have? 21 A. Yes, I think it led to a lot of change but, you know, 22 change applies unequally, not always in all places at 23 the same time. But I think it drove a step-change 24 across the NHS, not just in England but in the UK. 25 Q. Thank you. I wonder if we could look, please, at Page 119
1 devolution, effectively. There was a 1998 UK executive 2 letter, I think it's called, which sets out some 3 principles -- we may come to that in a moment -- and 4 indeed, as I think you've identified, there were further 5 Scottish Government developments of that in the 6 post-devolution period, showing a continuum of clinical 7 governance coming in. 8 We'll talk about that in a bit more detail in due 9 course. But just in terms of the circumstances of the 10 Bristol story, if you like, you've mentioned already it 11 was to do with paediatric cardiac surgery, is that 12 right? 13 A. Yes. 14 Q. And I think my understanding is that, given that we 15 start our story from 1995 onwards, I think the period, 16 in terms of where the actual treatment or harm was 17 happening, was before that, is that right? 18 A. Yes, I would have to refer back to the report to be 19 really clear about it but I think it goes back to the 20 late 1980s, very early 1990s. 21 Q. That's precisely my understanding. So in many ways it 22 is quite an important thing to consider because where 23 that leaves off, our journey begins, if I can put it 24 that way. And we mentioned at the beginning the 25 importance of being able to place in time what was Page 118	1 a short article you helpfully produced to us concerning 2 the Bristol case. It will come up on the screen. It's 3 ELJ0003-00150. This was an article that you helped us 4 with -- you put in I think, which is from the British 5 Medical Journal. Perhaps illustrating your point, it's 6 in 1998 so it's a few years before the report actually 7 comes out but it's already telling us quite a lot about 8 what the case and the Inquiry had uncovered, is that 9 right? 10 A. Yes, so this was written by Richard Smith who was then 11 the editor of the BMJ. 12 Q. Indeed, absolutely. So this is entitled: 13 "All changed, changed utterly. 14 "British medicine will be transformed by the Bristol 15 case." 16 And it tells us a bit about the background and in 17 the second paragraph, tells us: 18 "The trust between doctors and patients works on two 19 main levels: between individual patients and doctors and 20 between society and doctors' organisations. The Bristol 21 case will affect both. The most profound -- but least 22 easily measured -- effect may well be on the 23 relationship between individual doctors and patients. 24 In the past two weeks the case must have been in the 25 minds of many patients consulting doctors, particularly Page 120

1 those about to undergo operations. Worldwide, the 2 doctor-patient relationship is changing. For instance, 3 the main theme of last week's world conference of 4 general practitioners in Dublin was the change from 5 patients being passive recipients of care to being 6 active partners in all decisions; it was also the theme 7 of the first conference to celebrate the 50th 8 anniversary of the NHS. Evidence is growing that as 9 patients become equal partners in the doctor-patient 10 relationship then outcomes and satisfaction improve and 11 costs fall. If the Bristol case hastens the move to 12 patients being treated as equals it will have produced 13 real benefit." 14 So I'm just going to pause there because that's 15 reminiscent, I think, of the discussion that we all had 16 at the beginning about the timing of this move to a more 17 individualised experience of care and that coinciding 18 with the information we heard from one of our 19 neurosurgeons, that he felt that that had happened 20 by 1995. But by 1998 that change, that very real change 21 is being reflected in the article, is that fair? 22 A. It's certainly being reflected in the pages of the BMJ. 23 Q. Yes, indeed. So this is the change that should be 24 happening, if I can put it that way? 25 A. Yes. Page 121	1 announced on television that all three of the doctors in 2 the Bristol case should have been struck off (only two 3 were)." 4 As you just told us: 5 "He has met several times with parents of the 6 Bristol children, and it is understandable that he has 7 been affected by their grief and outrage. Less 8 understandably, he may also have been influenced by 9 Labour Spin doctors' interpretation of public opinion." 10 And then, in the final paragraph, the last full 11 paragraph down at the bottom on the left, if we can 12 scroll down a bit, it concludes: 13 "Moreover, reforming the GMC misses the point: 14 regulation of doctors is not all about the GMC. 15 Innumerable groups influence the practice of doctors, 16 and some of them, I have argued elsewhere, have much 17 more influence than the GMC. The council may control 18 the ultimate sanction of removing a doctor's licence to 19 practise, but its influence is not felt every day: to 20 the average doctor it feels distant. In contrast, 21 teachers and colleagues have both power and everyday 22 influence. Royal colleges and postgraduate deans also 23 have great influence, and they must recognise their role 24 in self regulation. It is this local, everyday self 25 regulation that has been especially weak, [and] there Page 123
1 Q. Thank you. It goes on to say: 2 "The Bristol case ..." 3 As it describes the circumstances in this article: 4 "... has already accelerated the move to provide 5 patients with data on the performance of doctors and 6 hospitals, and this has to be a good outcome. 7 Cardiothoracic surgeons have already taken impressive 8 steps, but they are way ahead of the pack. Doctors in 9 other specialties, particularly non-surgical ones, are 10 going to have to think hard and fast about how to gather 11 and present data on their performance. Neither 12 gathering nor interpreting the data is easy, and experts 13 on improvement emphasise that such data are best used as 14 a source of knowledge for improvement rather than for 15 judgment. If the Bristol case leads to an environment 16 where we concentrate on removing bad apples rather than 17 improving the whole system then both patients and 18 doctors will suffer. There must be mechanisms for 19 responding to doctors whose performance has deteriorated 20 to an unacceptable level, but such mechanisms will never 21 bring about the systemic improvements we need. 22 "Although dramas like the Bristol case are powerful 23 levers for change, they tend to lead to key protagonists 24 overreacting. Frank Dobson, the secretary of state for 25 health, made a serious mistake last week when he Page 122	1 are now signs that it is being taken seriously. The 2 challenge is to maintain the impetus for improvement 3 created by the Bristol case and turn fine words into 4 effective actions. 5 "The consequence for the British medical profession 6 of failing to act effectively could be serious. The BMJ 7 and other journals publish many studies showing that 8 doctors fail to practise in line with the best evidence 9 and continue to provide poor service: just last week the 10 BMJ published the results of a confidential inquiry 11 showing poor care of many patients before admission to 12 intensive care units. The government has proposed in 13 its white paper the concept of clinical governance, 14 which means that trust boards will be responsible not 15 only for financial and legal affairs but also for 16 ensuring a high standard of clinical care. It remains 17 ambivalent over how much clinical governance is 18 management of or management by clinicians. Failure of 19 doctors' organisations to implement much better 20 mechanisms for ensuring high quality care may lead to the 21 micromanagement of doctors that is routine in the 22 United States." 23 So what this is laying down, based on the Bristol 24 evidence and in the emerging clinical governance 25 picture, appears to be, as I understand it, that Page 124

1 a challenge is being laid down to maintain the impetus 2 created by Bristol and turn fine words into effective 3 actions. Now, you, given your involvement in that 4 Inquiry but also in the years after, will be able to, 5 I think, help us encapsulate what it was in a practical 6 sense that was being taken out of Bristol and how the 7 change should have manifested itself, if you like, for 8 patients at the coalface? 9 A. It's interesting that you quote at length that. I think 10 that editorial captures the zeitgeist at the time very 11 nicely and that sense of a turning point. You know, the 12 title -- I can't remember which poet he is quoting, but 13 "all is changed" -- it's Yeats, isn't it -- "all is 14 changed" really captures that sense there needed to be 15 a profound way in the way the profession worked. More 16 prosaically, that then played out in legislative changes 17 in the early 2000s which, as I've already said, 18 introduced the system of inspection and regulation for 19 healthcare providers but importantly also led to really 20 fundamental reforms of the General Medical Council. And 21 those reforms, despite what you see in that paper, those 22 reforms were not universally popular at all with the 23 medical profession and with associations, organisations 24 like the British Medical Association and took quite some 25 time to play through. Page 125	1 Standards Authority. 2 It was given statutory powers to oversee those 3 regulators, including importantly, for the first time, 4 the powers to take unduly lenient decisions by the GMC's 5 tribunals back to the High Court for review. And to do 6 performance reviews of those regulators, and then the 7 big change was that the GMC moved -- and this is where 8 I'd have to check the dates, moved from being a body 9 where the council was elected to being a body where the 10 council was appointed by the Privy Council, to represent 11 employers, registrants, educators and healthcare 12 providers. 13 So this was a time of really big change in the GMC 14 and that's one of the reasons why it took quite some 15 time for revalidation to become a reality. And the 16 GMC's original plans for revalidation, which were 17 regarded as -- a phrase we've used before -- something 18 of a tick-box exercise, were much criticised in 19 Dame Janet Smith's report in 2005, the Shipman Inquiry. 20 She dedicated one volume of her Inquiry to the GMC, was 21 very critical of its processes and that drove rethinking 22 about the process for revalidation, which was eventually 23 introduced in 2012. The first round of revalidation for 24 doctors in the UK completed in 2016, so 16 years after 25 the initial proposals. Page 127
1 So in the wake of this and the Bristol report, the 2 then president of the GMC, Sir Donald Irvine, absolutely 3 endorsed and drove through council the idea that the 4 profession should embrace revalidation, which was the 5 idea of having a periodic check on the fitness to 6 practise of every doctor who was on the medical 7 register. 8 It took till 2012 for that system of revalidation to 9 be introduced and it took that long because it was 10 a contested, difficult debate in which the GMC itself 11 found -- in those days, the GMC, its membership was 12 majority-elected by registrants. So on the GMC council, 13 there were many registrants who really were not 14 supportive of this development. Sir Donald Irvine wrote 15 a book called The Doctors' Tale, which described his 16 experiences of being president of the GMC, including 17 facing a contested election as president from people on 18 council who really didn't want to pursue some of the 19 things Donald Irvine endorsed. In the end -- and 20 I'd have to check dates here, but between 2003 and 2006, 21 the systems recommended, I think by Kennedy in his 22 report, were introduced to provide a new body that 23 oversaw all nine professional regulators, the GMC 24 amongst them. So that was the Council for Healthcare 25 Regulatory Excellence, what is now the Professional Page 126	1 Q. Thank you very much indeed, Professor Walshe, for the 2 whistle-stop tour of that important aspect and you've 3 honed in on something obviously -- and from the report 4 I think you also think is important to the time 5 period that we're looking at. 6 Because if we look at the challenge that's set down 7 in the article in the aftermath of Bristol, or indeed 8 the latter stages of Bristol in 1998, then you've honed 9 in on one aspect which is of particular interest to us 10 which is the revalidation and appraisal system. 11 Now, just for the sake of people who may not 12 understand the systems as well as you do, this was 13 a system which was eventually introduced, we've heard in 14 some evidence, in December 2012, is that right? 15 A. So appraisal, as I think Dr Gilder said earlier, had 16 been at least an intended requirement since the early 17 2000s but what revalidation did was to introduce 18 a requirement for an annual appraisal and for all 19 doctors in any organisation, wherever they worked, to be 20 undertaken by an appraiser, using a defined set of 21 supporting information which would include information 22 on complaints, compliments, performance, feedback from 23 colleagues, feedback from patients -- there might be one 24 or two items I have not listed there -- and that every 25 five years, the responsible officer, the designated Page 128

1 doctor in the organisation, the employed doctors, would 2 provide a recommendation to the General Medical Council 3 which could either be that the doctor was revalidated 4 for a further five years, or that their revalidation was 5 deferred. 6 Q. Okay, so there are two components to this system, as 7 I understand it. One is the revalidation process that 8 you have just talked about, which involves there being 9 a requirement every five years effectively to have one's 10 licence to practice as a doctor revalidated by the GMC, 11 is that right? 12 A. Yes. 13 Q. And in order to be able to be successful in that, there 14 requires to be put together a body of evidence 15 supporting that and there is someone called the 16 responsible officer, within a body such as a health 17 board, who is involved in pulling that together and 18 effectively making a review of the situation and some 19 sort of recommendation about whether that should happen, 20 is that right? 21 A. Well, the annual appraisals would be conducted by 22 designated appraisers in every body. The responsible 23 officer would not do all the appraisals, they would make 24 the recommendation on revalidation based on appraisal 25 evidence. Page 129	1 would sit down and analyse that material, albeit for 2 some, as you've told us, that might be difficult to pull 3 together, that was something that did go on in the 4 period from -- if we want to call it the "post-Bristol 5 period" up till 2012, but didn't lead, 6 until December 2012, to the revalidation part; is that 7 accurate? 8 A. That's right and it was more formalised once 9 revalidation was introduced. So I referred to that 10 portfolio of supporting information. The guidance on 11 that came out from the GMC and the NHS England and 12 equivalents in the other countries of the UK as part of 13 the push towards revalidation. I think Dr Gilder may be 14 better placed than me to comment on how formal 15 revalidation was prior to that. 16 Q. Indeed, I was hoping to do exactly that, set up the 17 system and the issue. So an issue you have identified, 18 before we get into the details of what actually happened 19 practically, which is very relevant to the relevant 20 period we are looking at, is that in the aftermath of 21 the challenge that was laid down by Bristol to 22 revolutionise the system, what had been anticipated 23 would be that there would be a system of revalidation 24 supported by appraisal, as you've told us, but that, for 25 various reasons that we may come to, that sanction, if Page 131
1 The pulling together of information for the 2 appraisals was a point of some contention because 3 doctors were themselves responsible for making sure that 4 information was available, and they relied on their 5 organisation, for example to bring together information 6 about any complaints, to source data about levels of 7 activity, numbers of operations or procedures, outcomes 8 and so on, and to support them in getting, for example, 9 feedback from patients and colleagues. 10 So the systems of revalidation appraisal and 11 revalidation worked reasonably well for doctors who were 12 employed in big organisations like NHS trusts and 13 boards. It worked much less well for doctors who didn't 14 have a straightforward employed relationship. Locum 15 doctors would be a really good example. They found it 16 hard to fulfil the requirements of revalidation. 17 Q. Understood. So we take revalidation, we understand what 18 that is. Now, my understanding is that the revalidation 19 aspect didn't come in until 2012, is that right? 20 A. Yes. 21 Q. But before that, I think what you've told us, is that 22 the other component, albeit it didn't lead to the 23 five-year review until the period after December 2012, 24 the appraisal part, where information required to be 25 produced and there was an annual appraisal where someone Page 130	1 you like, of the need to revalidate every five years did 2 not kick in until many years later, is that right? 3 A. It is. 4 Q. That obviously is important in the period in which we 5 are looking because that is a period over which certain 6 individual patients have concerns about the way in which 7 they were treated. So in the period from say 2002, the 8 post-Bristol period when, as I understand it, the 9 appraisal system came in, and 2012, we're really looking 10 at almost the entirety -- not the entirety, but a large 11 part of our relevant period, and therefore a large part 12 of a period over which people have concerns about 13 whether there was an effective system of oversight, 14 appraisal and monitoring of what Mr Eljamel, their 15 neurosurgeon, was doing. So this is a very important 16 contextual aspect for us. 17 And I would be interested to know, just before we go 18 to the practical details, I think you mentioned that 19 there had been at least a reason -- or part of the 20 reason why this did not happen, over that roughly 21 ten years period was that there had been resistance on 22 the part of the doctors. I think maybe you mentioned 23 the BMA. What was the reason why it took so long for 24 this system, which seemed to be being supported in the 25 aftermath of Bristol, not coming in until December 2012? Page 132

1 A. Again, I think Dr Gilder may have views upon this. We 2 did the national evaluation for the Department of Health 3 and Social Care of revalidation of England in 2016, 4 2017. And in summary, I would say the view of many 5 doctors was this was the imposition of a bureaucracy 6 which they didn't think provided them with a great deal 7 of value or help, and which, in quotes, they would often 8 say, "It would never catch another Shipman". In other 9 words, it would never detect somebody who was 10 deliberately harming patients. I think that 11 misunderstood the purpose of revalidation. It was not 12 about catching another Shipman. It was, as 13 Richard Smith said in his editorial, about lifting the 14 performance of all doctors through a process of review, 15 and constructive appraisal and feedback and then 16 improvement. 17 Not all doctors were necessarily of a reflective 18 personality that enjoyed or wanted to take part in 19 a process of appraisal and they wanted to get on with 20 their work. So it was a challenge and I think, for 21 those in implementing it, the process of implementation 22 became the purpose, in the sense that you would hear 23 from people involved in trying to get revalidation and 24 appraisal ruled out: we need to get the system in, we 25 need to get it working, we need to get everyone taking Page 133	1 reality of working in a hospital at that time. 2 Professor Walshe has told us about the doctors having 3 resistance, there being institutional resistance, but 4 what did it mean, for example -- obviously the system of 5 revalidation and appraisal was designed, as the article 6 said and Professor Walshe said, to try and lift 7 standards to make people realise that they're going to 8 need to, to an extent account for what they are doing, 9 to other people or to another agency. And was it the 10 case, over this period, that there was engagement in, 11 for example, the appraisal part that did exist, or was 12 there a general resistance to the bureaucracy that 13 Professor Walshe has described? 14 DR GILDER: I think -- there was an acknowledgement that it 15 needed to happen. As always, it's about the implication 16 and the implication being meaningful and for the doctor: 17 what's in it for the doctor? I think one of the very 18 important things here -- the appraisal required 19 a gathering of a huge amount of information, it was 20 actually quite hard work to do an appraisal, it required 21 logbooks, it required a lot of evidence, it required 22 collating patient feedback, whether that be positive or 23 negative and that was -- and colleague feedback, 24 positive and negative. There was also an expectation 25 that you demonstrated that you were involved in quality Page 135
1 part and then we can worry about trying to reform it or 2 improve it to make it more effective. 3 Q. And the resistance you're talking about is by individual 4 doctors or groups of doctors, but was the resistance at 5 a more institutional level as well? 6 A. So the Royal Colleges were all pretty much on board with 7 revalidation. In fact, originally they were going to 8 take a larger role in the design of revalidation than 9 they did in the end. I think the British Medical 10 Association responds to the interests of its members, so 11 it was much more sceptical about the introduction of 12 revalidation. And as I have said, in the early days, 13 certainly pre-the Shipman Inquiry report, was quite 14 active in questioning whether this was going to be of 15 value. 16 Q. So that was in the period 2002-2005? 17 A. Yes. 18 Q. And then there was still a considerable delay after 19 that? 20 A. Yes. 21 Q. So if I could turn to Dr Gilder now, I'm interested in 22 obviously understanding, Dr Gilder, given the importance 23 of this background to the period that we are looking at 24 and the sorts of concerns with which the Chair will 25 ultimately be concerned, as to what that meant for the Page 134	1 improvement. So appraisals, just to take a step back, 2 they had four domains that matched the GMC four domains. 3 So the first domain was "knowledge, skills and 4 performance" and you had to submit evidence that you 5 were up to date, that you were skilful, that you were 6 performing. So what that could look like, for example, 7 is if you're employed to do a clinic a week in 8 something, that you would have evidence that you did. 9 Doctors get about ten weeks' holiday pressure leave 10 a year, so 52 minus 10, that you went to 42 clinics on 11 a day, for example. And then you had to demonstrate, 12 within knowledge, skills and performance, that you were 13 actually practising, you were administering best 14 practice. So that was the first one. 15 The second domain is "safety and quality" and that 16 domain, that included complaints and compliments, that 17 included incident reports, that included participations 18 in efforts to improve the quality of your service. So 19 that might be an audit, it might be a service review. 20 Our academics would submit the work that they did as 21 evidence that they were participating in safety and 22 quality. And there was also evidence that was 23 absolutely required about your continual professional 24 development, which actually sat in "knowledge" and you 25 actually had to submit evidence that you had been to Page 136

1 academic meetings and you needed to write a reflection 2 on those academic meetings. 3 So we had to -- we still have to demonstrate -- so, 4 for me, I had a particular structure of approach, I'd go 5 to a national meeting, I had three particular 6 sub-specialties. I go to a national meeting every year 7 on those and an international meeting every three years 8 on those and then I would go to some local interest 9 meeting which would build a proportion of that. And 10 that's because the knowledge, if you like, base doesn't 11 really change more than every three years, so there's no 12 real -- if you go every year, you pretty much hear the 13 same. So I had an approach. But then I had to document 14 those, so I had a document -- you get CPD points 15 according to the number of hours that you are at this 16 conference and I had to describe what I learnt. 17 So that was -- that -- again, the right thing takes 18 quite a lot of time. 19 The third domain is "communication, partnership and 20 teams". This is where colleague feedback, patient 21 feedback is really, really important and also 22 demonstrates how you -- if you had managerial 23 responsibility, leadership responsibility, you would put 24 those in there. 25 Then the final one was "maintaining trust" and part Page 137	1 Fay, pat, pat, off you go. And that actually really 2 mattered, to be able to have -- 3 And then finally there was payment, or time 4 allocated -- to be an appraiser, you actually spend 5 quite a lot of time reviewing the evidence. And we had 6 so many appraisees allocated to us. And in the end, 7 there was funding -- in 2012, there was a recognition 8 that this required time or money and it was within my 9 job plan. Cambridge took the approach that it was 10 within your job plan -- you were given time as 11 an appraiser in your job plan to do the work around 12 an appraisal. 13 So to have a really effective system you needed: 14 one, a way of getting really good evidence; two, 15 an outcome that mattered to the appraisee; three, the 16 skill of the appraiser; and four, time to do it -- time 17 for the appraiser to do it well. 18 And I think those are really important and when some 19 of that is missing, you lose confidence in the appraisal 20 process. 21 So obviously I'm talking about when the appraisal 22 is -- the process was established. But lots of people 23 were looking, saying: well, will I get time for that, 24 how will I get time for that, how will I do this well? 25 But the other element is that level of scrutiny and Page 139
1 of that was demonstrating you were healthy, 2 demonstrating that there were no concerns about your 3 probity and again, back to relationships with patients 4 and colleagues. 5 So those are the four domains. And it requires -- 6 it's a lengthy and involved process to do it well. 7 So that's one side. 8 So the other side is the quality of the appraiser. 9 So you sit -- and we're all trained -- well, not all of 10 us, but those of us who want to be appraisers go through 11 appraisal training. And the expectation for that 12 appraisal is that something comes out of it, and it's 13 amazing actually. I was -- you sit in with your 14 colleagues and you see how much they do and you 15 recognise how much they do, but a lot of that doesn't 16 come out into the open, but some of this is about the 17 questions are: what do you need? You know: what 18 resources do you need to do this further? 19 And I think that was a bit that was missing often is 20 that you put all this work into an appraisal and then 21 you just go: well, that's great, see you next year. 22 There's an element about, you know, what does that 23 really mean? 24 There is the quality of the appraiser themselves. 25 I've certainly had appraisers say: yes, yes, well done, Page 138	1 trusting what the scrutiny will be and trusting the 2 outcome of that scrutiny. So perhaps -- so, if you did 3 have a significant complaint against you or you did have 4 a serious adverse event, which is possible, not because 5 of your poor skill but because sometimes things happen, 6 it's trusting that the system would treat that in 7 an investigative way in which it was not a blame thing, 8 it was a: let's do this properly and look at it 9 properly. And so it was really confidence that this was 10 all going to work well but also that you are -- what you 11 were talking about was -- it was a safe space. 12 In a very similar way as to job planning, doctors 13 don't really like or trust scrutiny. It's 14 uncomfortable. And so I think part of the objections 15 was this -- what would have been seen as managerial 16 scrutiny. And again, there's a whole piece of culture 17 which is the relationship between managers and doctors. 18 So if you want to look at why did -- or what were the 19 objections to appraisal, part of that will be the 20 relationship between who was it -- who was making you do 21 it, and were you actually part of the decision-making 22 yourself. 23 But on the ground now, it's accepted. But 24 I think -- I still think it goes back to what I said 25 needs to happen. You need all of those things in place Page 140

1 for it to be something that's meaningful and it's 2 actually quite difficult. So the other thing that's 3 difficult are the sanctions if you don't do your 4 appraisal. It's a very -- the sanctions that we have 5 through the GMC don't have a huge amount of teeth until 6 you get to third year where someone hasn't done their 7 appraisal and then we begin to say: we're going to take 8 you off the register, we're going to go through that 9 process. 10 So there's a small number -- as everywhere, bad 11 apples, a small number of doctors. Some of those 12 doctors, indeed in my trust, were neuro-atypical and had 13 difficulty with the organisational element of this and 14 in fact, I picked up some of those and was able to 15 support those. But fundamentally, there were some 16 people who just didn't engage and that non-engagement 17 sanction with the GMC still isn't all that strong, it's 18 not that powerful, not that effective. And so I had 19 quite a lot of -- I mean, we got there in the end, but 20 it's a really difficult and time-consuming process to 21 get the rare individual who just doesn't want to engage, 22 to engage. 23 Q. Thank you very much. A lot of important concepts in 24 there. So if I could pick up on a few of them just to 25 try and understand a little bit better. Page 141	1 Q. And if a doctor were, for example, of the view that 2 there was insufficient staffing within the unit that 3 they worked in, would it be important in the system for 4 the doctor to be able to raise that, to say: look, 5 I'm struggling with my practice but there are reasons 6 beyond my control you need to help me with? 7 A. Yes. 8 Q. And that's part of the two-way street? 9 A. Yes, and that comes both into the job planning 10 conversation and the appraisal conversation actually. 11 They are two environments in which you can have and 12 raise those concerns. 13 Q. Indeed. I was just going to say precisely that because 14 that might also be an aspect. It might be there's 15 enough resource but the way in which that resource is 16 organised. If you're a surgeon, for example, when the 17 theatre sessions happen and who is there to support you, 18 the job plan and the number of commitments you might 19 have might need re-organisation and that would be 20 something that a doctor could bring to the table in 21 an appraisal, is that right? 22 A. Correct, yes. 23 Q. Other aspects of the appraisal that you told us about 24 I think involved there being a -- if one looks at it 25 from the other side, what it is you have to establish, Page 143
1 I think what you were telling us -- one of your main 2 points was in order for the system to work well, there 3 needed to be an element of kind of a two-way street 4 about it, would that be fair? 5 A. Yes. 6 Q. And in order to try to get doctors who might be 7 sceptical, particularly in the period we're looking at 8 where this is a newish system coming in, with their 9 perhaps scepticism about managers asking them questions 10 and being under scrutiny. It was necessary to be able 11 to have a system which enabled the doctor to put the 12 effort in that was required, to provide the evidence 13 that was needed for a proper appraisal to be done but 14 also that it should be recognised as something that 15 might benefit the doctor as well; is that correct? 16 A. Yes. 17 Q. So that might involve, for example -- I'm just 18 hypothesising, it might involve a situation in which, if 19 a doctor was struggling or if a doctor had concerns 20 about the way things were going, that they would be able 21 to raise those -- and I think you talked about it -- the 22 phrase "just culture" is used in places, that it would 23 be raised without blame necessarily; is that 24 an important part of the system? 25 A. Yes. Page 142	1 if you like, is that it was very important that there 2 was a comprehensive and reliable evidence base, is that 3 right? 4 A. Yes. 5 Q. And I think Professor Walshe already told us that for 6 some people that was difficult to compile for practical 7 reasons, but that evidence was important, yes? 8 A. Was -- is still. 9 Q. You told us one of the things that would be part of the 10 appraisal process was to try to make sure that you could 11 vouch that you were attending in the way that you were 12 required, is that right? 13 A. Yes. 14 Q. And another aspect, I think, was that you were able to 15 bring to the table information that would demonstrate 16 that you had interacted well and constructively with 17 other colleagues, is that right? 18 A. Yes. 19 Q. And I think also you mentioned that it would be 20 necessary to bring to the table information that would 21 demonstrate that you met, what we understand from other 22 places, to be high standards in the medical profession, 23 probity, would that be right? 24 A. Yes. 25 Q. The word "probity" has come up an awful lot in the Page 144

1 evidence that we've heard and some have identified it as 2 being a word that occurs only in medical regulatory 3 documents. In fact, it was helpfully suggested to us by 4 one of the other experts that he preferred the word 5 "integrity", but is it the same sort of concept? 6 A. Probity means that you're entirely truthful, or that's 7 how I interpret it because we actually had to hold -- we 8 had difficult conversation with consultants in whom 9 probity was an issue and it's about telling the truth. 10 Q. Yes, and indeed, you told us some other aspects of this, 11 that it would be important to demonstrate you had 12 engendered trust in others? 13 A. Yes. 14 Q. It would be important that you could demonstrate that 15 you had maintained an appropriate level of what I might 16 call technical skill? 17 A. Yes. 18 Q. And that involved, I think, evidence about your actual 19 work but also attendance at continuing professional 20 development sessions? 21 A. Yes. 22 Q. And indeed, it was necessary, I think you told us, to 23 bring to the table also evidence about where things 24 might not be going so well, for example if there had 25 been complaints? Page 145	1 isn't routine and I think that would actually be 2 a big -- would be -- made it more of a -- if you want to 3 go back to the comment about: we wouldn't have picked up 4 another Shipman. No, you might not have picked up 5 a Shipman, but you would have picked up an Eljamel from 6 patient complaints. 7 Because I currently rely on -- and when I was 8 involved as medical director with complaints and 9 inappropriate behaviour, my comment to the consultant 10 was: this has to go into your appraisal, but I'd copy it 11 in to the individual who ran the appraisal system, so it 12 was already marked within the appraisal, so it would 13 definitely come up. But there was an individual 14 practice of mine, it wasn't a systematic response to 15 there being a complaint against a particular doctor. 16 Q. Understood. We'll come to you in a second, 17 Professor Walshe. But just on that point, it was 18 important then that this system would be an opportunity 19 for a reasonable, representative portion of reliable 20 evidence to be put before an appraiser such that the 21 appraisal would actually mean something, is that right? 22 A. Correct. 23 Q. We talked about the importance of evidence in terms of 24 being provided about someone's practice, but it would 25 presumably also be important that the process be Page 147
1 A. Yes. 2 Q. And in order to be able to do that, there would need to 3 be an effective complaints systems that would enable 4 a representative body of material to be put before the 5 appraiser? 6 A. Yes. 7 Q. Because, for example, if there were a system that was 8 impossible to access, but you had 10 patients who were 9 upset with the service, that material wouldn't get 10 before the appraiser because there wouldn't be a system 11 of complaints that would enable that to happen? 12 A. So what you would get, as an individual doctor, is you 13 would be aware someone has complained against you and 14 for many years you would be expected to provide 15 a response. What I, as an appraiser, wouldn't have 16 would be the triangulation. So from my Datix report, 17 when I clicked on this particular person I was 18 appraising, that there were or were not any complaints. 19 So it did rely on self reporting and I remain in the 20 belief that that is a weakness of the current appraisal 21 system, is that it is in good organisations -- for want 22 of a better description -- these will be provided to the 23 appraiser. The doctor didn't provide it -- well, the 24 doctor would have to discuss it, but I would have it 25 independently of the person I was appraising. And that Page 146	1 evidenced properly, that the evidence had been provided, 2 that the appraisal -- 3 A. (Overspeaking) yes, the investigation was done, 4 et cetera, et cetera. So you weren't just getting 5 somebody who was maliciously complaining against 6 a perfectly excellent doctor. That's not what you want, 7 you want -- 8 Q. (Overspeaking) Indeed, sorry, we're slightly at 9 cross-purposes. I'm asking about -- you told me that it 10 was important that there be a good system for collecting 11 evidence that could then go before the appraiser, but 12 I'm asking, it would be logically the case that for the 13 process to work there should be proper documentation of 14 the appraisal process itself? 15 A. Yes, and there is. 16 Q. Or at least should be? 17 A. Yes, and we are all required -- we have to use automated 18 systems now. Then, we didn't. Then there were 19 different forms and prior to that, there was 20 paper-based, but, yes. 21 Q. You set out, for a number of very important reasons, the 22 importance of this system and when one looks at it in 23 the context of Bristol and the article we looked at, it 24 seems very understandable as to why a system like this 25 was deemed necessary. Over the period that we are Page 148

1 looking at, you reflected earlier in our conversation 2 this morning about the fact that there were doctors who 3 were happy to go along with this, who were happy to be 4 part of a revolution or evolution that was happening. 5 But there were others who were not prepared to be part 6 of it. And if someone, over this period that we're 7 interested in, this 2002, 2012 period, didn't want to be 8 part, was part of the group that was resistant to it, 9 how easy would it have been to resist it? 10 A. As -- almost as easy as it is today. It's harder today 11 because you get nagged, for want of a better descriptive 12 word, because you are chased to get your appraisal in 13 but certainly, if somebody didn't want to appraise -- 14 they wouldn't -- it would take some -- it would take 15 more -- it would take some time to get that individual 16 to toe the line and by "time", I would describe that 17 in years because it's an annual appraisal. 18 Q. Right, and just an aspect of appraisers and appraisees, 19 people in leadership roles would also need to be 20 appraised in the sense that they are -- is that right? 21 A. Yes, I was appraised but I was appraised by someone 22 independent of my organisation, a higher-level 23 responsible officer, for example. Yes. 24 Q. Yes, so even when one is a responsible officer, as 25 you've been, you need to be appraised by someone? Page 149	1 a large minority of NHS consultants also work in private 2 practice. So the doctor is expected to bring to their 3 appraiser information about their private practice. 4 There isn't a mechanism for the appraiser or for the 5 responsible officer in the designated body, which will 6 be their NHS board or trust, there isn't a mechanism for 7 organisations to know where the doctors work in private 8 practice. They could work at one, two or more different 9 private healthcare providers. So it's, again, about 10 self disclosure. The onus is on the doctor to bring 11 evidence from their private provider to take part in 12 their appraisal. 13 There's no mechanism then for necessarily feeding 14 the information from the appraisal back to their private 15 provider. That again, relies on responsible officers 16 and appraisers and the consultant themselves being 17 willing to share information. 18 The system also falters somewhat when doctors move 19 between organisations, so when a doctor moves job from 20 one organisation to another, making sure their appraisal 21 history is able to follow them. There is a process laid 22 out for transferring information especially when there 23 have been concerns. In practice, it relies very heavily 24 on discretionary effort by responsible officers. And 25 it's not even necessarily straightforward for the Page 151
1 A. Yes. Anyone who has a registration with the GMC, 2 active, has to have an appraisal every year. 3 Q. And we discussed this actually with the very first 4 witness who gave evidence, that it might be thought 5 within an organisation that people who are at a very 6 high level don't need to be appraised because they're 7 fine, they know what they're doing, but in fact, as we 8 discussed with literally our first witness, in many ways 9 such individuals need more appraisal because if they 10 have a problem, if their practice dips below 11 an acceptable level, for example, because of the fact 12 that they have such wide responsibility, the potential 13 ramifications of that are much wider? 14 A. They are. 15 Q. So you, obviously based on your own experience, I think 16 agree -- 17 A. I do. 18 Q. -- that leaders must be appraised also? 19 A. They must be. 20 Q. Thank you. Sorry, Professor Walshe, you wanted to -- 21 PROFESSOR WALSH: I just wanted briefly to add something to 22 what Dr Gilder has said and that is that there are 23 a number of kind of holes in the system. One of them is 24 that this system of appraisal and revalidation is meant 25 to cover your whole scope of practice as a doctor. Now, Page 150	1 responsible officer in an organisation where a doctor 2 leaves, to know where that doctor has gone. 3 Final point. The whole system relies on what are 4 called "designated bodies". So a designated body is 5 an organisation that employs doctors. So that could be 6 NHS Trust, it could be a locum agency, for example, or 7 it could be a really small organisation like a hospice 8 which employs two doctors. And the system works quite 9 well in big organisations like the trust where Dr Gilder 10 was a medical director. It works much less well in 11 smaller and atypical organisational settings. 12 And many people in our research said that doctors 13 who have performance problems will migrate to settings 14 where the extent of oversight is less. So one of our 15 big concerns -- in fact, we've done subsequent research 16 on -- was locum doctors, because it's easier to fly 17 under the radar if you don't have a strong 18 organisational affiliation to one organisation. If you 19 move, if you are peripatetic and if your track record is 20 therefore fragmented. 21 Q. Thank you, just to draw out a couple of quick points on 22 that. Your issues about the private NHS movement and 23 sharing of information, those exist even now, is that 24 what you're telling me? 25 A. Oh, yes. Yes. Page 152

1 Q. That's the current situation? And just on that aspect 2 of things, my understanding is that, in theory, one 3 would have one responsible officer - for a doctor? 4 DR GILDER: Yes. 5 PROFESSOR WALSH: Yes, in your designated body. 6 Q. So that would be the responsible officer in the place 7 where one would do the most work. So if one works, for 8 example, in a probably not atypical situation, in an NHS 9 hospital and one private hospital, the responsible 10 officer would be in the NHS hospital, yes? 11 A. Yes. 12 Q. But the appraisals that would lead to the revalidation 13 every five years, technically would require to cover the 14 entirety of the practice, is that right? 15 A. Yes. 16 Q. And so what you're telling us is that there is 17 a potential deficiency in the system in that it was 18 really up to discretionary participation as to how much 19 information about the private practice is in fact 20 leading into the appraisal, is that right? 21 A. Yes, it relies on the consultant providing that 22 information and asking their private hospital to provide 23 them the information to pass on. 24 Q. Yes, because there's a reliance, as you told us earlier 25 about locums, about being able to get the data because Page 153	1 A. That's right. 2 Q. Just in terms of the other organisations, would that 3 necessarily just be other hospitals, or would it be 4 things like universities and that sort of thing as well? 5 A. Yes, but really the concern is where they're working 6 clinically, so that would be predominantly other 7 hospitals but they could be working in outpatient 8 settings as well. 9 Q. Of course. Sorry, Dr -- 10 PROFESSOR FARRELL: I think Dr Gilder did want to say 11 something. 12 DR GILDER: So I think things are slightly different for 13 the -- certainly for the larger, private hospitals. So 14 for Spire, Nuffield, there is -- the first thing is that 15 the consultant is expected to, as part of the whole 16 practice appraisal, provide a certificate of good 17 standing from that private hospital. So the appraiser 18 would expect to see that. 19 Plus or minus -- and this is less proscribed -- 20 complications, readmissions if you're a surgeon, to that 21 private hospital. But the certificate of good standing 22 has come in as something that is a fairly established 23 part of a doctor's appraisal who works in the private 24 sector. So it is much, much better than it was even, 25 say, 8 years ago. Page 155
1 it's not necessarily at one's fingertips and the private 2 hospital might be the problem? It might be the doctor's 3 willing but the hospital hasn't provided the 4 information? 5 A. Yes. 6 Q. And just to understand, if everyone were willing, that 7 would also be a forum in which one could check matters 8 that kind of sit in between the two practices. For 9 example, if information was being provided that someone 10 was working, doing a lot of, let's say surgeries, in 11 a private hospital, that might throw issues in the NHS 12 appraisal to say: you're spending an awful lot of time 13 in the private hospital, how is that working with the 14 job planning in the NHS hospital? In theory, that's the 15 sort of thing that should be thrown up, is that right? 16 A. Yes, those concerns should be raised and it's worth also 17 adding that the guidance from the GMC -- and it is 18 guidance, it's not statutory -- it's very clear that if 19 the responsible officer has concerns about the practice 20 of a doctor, it is their job to make sure those concerns 21 are communicated to any other organisation where that 22 doctor works. And except figuring out where those 23 organisations are, as I said, is not straightforward. 24 Q. Because there's not a sort of official list of the 25 hospitals you worked in? Page 154	1 The second thing is the weakness that 2 Professor Walshe describes in terms of RO-to-RO 3 conversations. If something goes wrong in the private 4 sector, it can often take quite a while for the 5 responsible officer of that organisation to come to me, 6 the responsible officer who -- I am the responsible 7 officer for this individual, to tell me that something's 8 gone wrong. And very much, I'm dependent on the doctor 9 self-reporting a complication that's occurred. So that 10 is a definitely a weak link in the chain. 11 Q. Just on that point, is that again a feature of something 12 you mentioned earlier about different types of systems, 13 that it would be quite a lot of work for the responsible 14 officer to contact someone in other hospital -- 15 A. No, it is not actually. When I was in the unfortunate 16 position of suspending doctors, the first thing I had to 17 do was to tell the GMC and the second thing I had to do 18 was make sure I told every organisation where they 19 worked privately. 20 Then if we go on to job planning, job planning is 21 also a whole-practice process. So consultants are 22 expected -- and again, this is self-reported -- are 23 expected to describe every hospital that they work in 24 and how much time they spend in it. Because 25 a whole-practice appraisal also is a reflection on how Page 156

1 much time you're working in any form of clinical 2 practice and that includes your managerial and other 3 teaching responsibilities, you're supposed to look at 4 your whole practice. 5 So in theory, the organisation, your designated body 6 would know the other hospitals where you work because 7 that is required information for your job plan. And 8 that is also prescribed as an expectation and the BMA 9 says the same thing, if you look at their private 10 practice regulations. 11 Then the final thing is what Professor Walshe 12 alluded to which is the transfer of information between 13 organisations about doctors when they move. It's 14 another weakness. The responsible officer is -- of the 15 new organisation is responsible, through their HR 16 processes, to request information about that -- well, 17 any concerns about that doctor to come from the 18 responsible officer from the prior organisation. And 19 it's done through an MPIT form, which is I think 20 a medical practitioner's information transfer, and any 21 reservations, any ongoing issues -- and we also have to 22 put whether or not we have told the doctor that we are 23 transferring that information over. So there is a way 24 of transferring that information which is confidential. 25 Unfortunately, it's, I feel, at the wrong end of Page 157	1 A. Yes, it does. 2 Q. But you're saying that it's often not available when you 3 need it? 4 A. Correct. 5 Q. And you've also helped us -- 6 A. (Overspeaking) And that's a GMC confidential process, 7 that is a GMC proscribed process. 8 Q. I see. That puts me in mind of another aspect that 9 you've helped us with which is to do with consultant 10 points and you've told us a bit about the history of all 11 of that. One aspect of that that we're interested in 12 exploring with you -- you've helped us with a lot of the 13 ways it used to work, the ways it works now and the 14 sorts of principles that should be applied. Do you have 15 a view, Dr Gilder, on the subject of the rigour with 16 which those who are responsible -- and different parties 17 are responsible at different times, as I understand it 18 for consultant appointments -- should interrogate the 19 information that they are given by a doctor in support 20 of an application to become a consultant? 21 A. If I'm very frank, I do not feel that the appointment 22 process for consultants is rigorous enough. 23 Q. In what regard? 24 A. I have written in here how it's done. You have 25 an advisory committee, there is a statutory make-up of Page 159
1 the -- I felt very strongly -- because I was exposed to 2 this as a -- we employed someone who, if I'd had the 3 MPIT before, I would not have employed. The MPIT comes 4 after the appointment is made and almost at the time 5 that the doctor starts their new appointment. And then 6 you get the MPIT and it has these reservations and 7 you're like: well, if I knew this I wouldn't have 8 appointed the doctor and it's all pretty much too late. 9 And I strongly feel that the MPIT should be something 10 that comes at the same time as the references and when 11 you're deciding whether or not to appoint that doctor, 12 and by the time we get it it's too late. 13 It's not particularly arduous. I mean, appraisal 14 has a whole system of administration underneath it. 15 You're given an administrator who runs it, tracks the 16 appraisers, sends out the letters on your behalf, 17 escalates a problem to you and then you -- if you like, 18 you do the final pathway of: why haven't you had your 19 appraisal or whatever. And they also run the MPIT 20 system. So it's not actually a very arduous process, if 21 you have good administration in place. But that remains 22 a weakness in the current day, where we do not hear 23 about poorly performing doctors from other organisations 24 until they've already been employed by us. 25 Q. I see and the MPIT would contain that? Page 158	1 that committee in terms of who does what and the 2 representation. There's an expectation that it's 3 a competency-based process and that you are expected 4 to -- the consultant is asked questions to demonstrate 5 that they're competent, that they have professional 6 skills, that they understand clinical governance, have 7 insight into themselves. Some hospitals will institute 8 more levels of assessment. So there are hospitals that 9 have several layers of assessment, I think those are 10 more robust, but there are other hospitals that just 11 have a 45-minute to an hour interview with the 12 individual and then will score that individual and it's 13 all documented. 14 But it's, I feel, quite a light touch approach to 15 what is -- I think I've written and I assert -- 16 certainly the most risky decision a hospital can make, 17 which is to appoint a consultant because consultants 18 tend to stick around appropriately for 30, 35 years 19 within your organisation and they are senior leaders 20 within your organisation and have, as we all know, 21 incredibly important responsibilities within your 22 organisation. 23 So I think more could be done in terms of the 24 appointment process of consultants, in terms of quality 25 assurance of who you're actually appointing and what Page 160

1 they're -- 2 THE CHAIR: Just as a matter of interest and very generally, 3 are these positions competitive, or are -- 4 A. (Overspeaking) Oh, yes. Open competition. 5 THE CHAIR: But does that depend also which part of the 6 country you are talking about, or is there a glut of 7 candidates for too few positions with a result that 8 you're always -- 9 A. (Overspeaking) Actually, often in smaller hospitals, 10 hospitals who are in the periphery of regions so not in 11 big centres, it's the opposite. It's very difficult to 12 appoint -- it's very difficult and in fact, in the news 13 at the moment is the case of the breast surgeon in 14 Darlington and how he was the only substantive 15 consultant supported by a host of locums. And in places 16 like that where it's very difficult to attract high 17 quality doctors, there isn't a glut and it's -- but the 18 responsibility of the AAC is to not appoint. 19 THE CHAIR: That was what I was going to ask you. It was 20 precisely point I was going to ask you because -- and 21 I'm not thinking about anywhere in particular, but just 22 in theory, there is, in this sort of situation, 23 a tension, I imagine -- 24 A. There is. 25 THE CHAIR: -- between the need to fill positions relative Page 161	1 consultant and a number of locums. What would the 2 concerns or dangers around that sort of situation be? 3 A. The quality of care delivered by the individuals. And 4 I think Professor Walshe may have more to say about 5 that, but for me the biggest concern I would have is 6 what is the quality of care for patients receiving. And 7 without -- no disrespect to those doctors who are 8 locums, we were -- in our services where we were more 9 dependent on locums, we would have usually more 10 incidents in patient care. 11 Q. That's because I think Professor Walshe -- maybe 12 a number of factors, but because of the sort of 13 peripatetic nature of things and not being able to 14 deliver the same level of service that one should be 15 able to deliver if one is there all the time -- 16 A. (Overspeaking) I can make a generalisation that locum 17 doctors are often doctors who have not been able to 18 secure a substantive consultant post. 19 Q. I see. I think Professor Walshe suggested -- 20 PROFESSOR WALSH: (Overspeaking) I'd just add the 21 Bill Kirkup Inquiry into East Kent maternity services 22 majors on this, describing it as a service run on locums 23 and describing the problems of having locums who were 24 insufficiently experienced to get on the specialist 25 register and therefore occupy a full-time consultant Page 163
1 to the quality, if you like, of the application and the 2 individual in front of you -- 3 A. There is. 4 THE CHAIR: -- and you say that there is a professional 5 responsibility to say if they're not good enough, they 6 don't come? 7 A. In the majority -- and I'd almost say every 8 organisation -- knows that if you appoint someone who is 9 not fit for purpose for a consultant, the trouble that 10 you're going to have for the next 35 years is not worth 11 it. But I think organisations and including my previous 12 one have definitely learnt that the hard way. 13 THE CHAIR: Thank you. 14 A. It's very hard but there are ways around. So you can 15 offer people locum positions, you know you can offer 16 people -- if you have a fellowship programme, you can 17 get them in a level that you don't have the 18 responsibility of a consultant but you can, if you like, 19 see how they settle in. But, yes, the most important 20 decision that an AAC can make is not to appoint. 21 THE CHAIR: Thank you. 22 MR DAWSON: Just to pick up on one aspect of that -- lots of 23 very interesting concepts very helpful concepts there, 24 Dr Gilder, but one in particular, I think you mentioned 25 perhaps an actual situation in which there was a single Page 162	1 post. I think it's a bit early to draw conclusions 2 about the Durham and Darlington case but again, there, 3 the Aubrey report has pointed to the fact that the 4 service was being run with a large number of locums, 5 including locums from filling consultant positions who 6 were not yet on the specialist registrar. There can be 7 routes, as Dr Gilder was saying, bringing people in as 8 a locum, mentoring them, supporting them in their 9 training, getting them on to the specialist register, 10 but that term "a service run on locums" is, I think, 11 a red flag. 12 Q. I wonder as well as the quality issue, maybe 13 Professor Farrell would have a perspective on this, it 14 maybe more of an ethical consideration that we looked at 15 with our ethics group, that we talked with them about 16 the ethical obligations on doctors effectively sharing 17 information with other doctors and to an extent, to be 18 overseeing the practice and supporting the practice of 19 other doctors, so there were ethical responsibilities in 20 that regard. Would that be more difficult in that sort 21 of situation where one is working with people that are 22 not permanent consultant colleagues but locums who may 23 be coming and going and maybe have different backgrounds 24 and experiences? 25 PROFESSOR FARRELL: Well, I suppose it depends what form of Page 164

1 ethics you might be talking about. Certainly, if you 2 are a registered doctor, you have professional 3 obligations and, you know, guided by the GMC, for 4 example, they don't disappear just because you're in 5 a particular employment relationship in that regard. 6 Q. I was meaning really the ethical obligations that 7 doctors have amongst themselves and to other colleagues 8 and to support and, to an extent, oversee and speak to 9 others. That, I suppose in a perfect environment, one 10 has a permanent consultant group who work well together, 11 that that would be happening all the time and it would 12 be a system of self regulation and self support. But 13 with more locums that might be more difficult to 14 achieve; would there be ethical considerations? 15 A. There may be but also you're straying into sort of other 16 areas of law and around employment relationships and 17 sharing responsibilities and I suppose the principles 18 that would guide that, that would be outside my 19 expertise. 20 Q. Thank you. To go back, what seems quite a long time ago 21 when we started with the passage, paragraph 4.1 that 22 I put to Professor Walshe, which has led off into many 23 interesting areas. One aspect of that, the passage that 24 I read out that I wanted to pick up with you. It's in 25 the final sentence, where you say: Page 165	1 Dr Gilder referred earlier, in talking about 2 appraisal, to the kind of relationship between doctors 3 and managers in healthcare organisations but the reality 4 is that the great majority of the managers managing this 5 in healthcare are doctors. So the people who are 6 clinical directors, the people who are medical directors 7 and associate medical directors, responsible officers, 8 you know, this is the medical profession managing its 9 own profession rather than -- and it's rare for it to be 10 non-clinical managers taking a very active role in some 11 of this decision-making. 12 But it remains true that the non-clinicians who are 13 the non-executives and the executive directors of health 14 boards and health trusts bear the ultimate 15 responsibility and the key concern was to make sure 16 there are those connections -- the phrase is sometimes 17 "ward to board", that you would know, at a board level 18 in the organisation, that you were assured that all 19 these systems we've been describing are in place and, as 20 you said earlier, are working and we can show that 21 they're working and are therefore giving us the 22 assurance that we are providing safe, high quality care. 23 Q. So in that relationship, the ward to board system, is it 24 the board's responsibility under these, at that time 25 emerging principles, but now established principles, to Page 167
1 "Specifically, in the relevant period, key 2 principles governing policy making, decision-making and 3 delivery of services in the NHS in relation to patient 4 safety, treatment and care in high-risk specialties, 5 such as neurosurgery, [would] have included the 6 following ..." 7 First of all, why is it that you describe 8 neurosurgery as "high risk" and why is it that, as 9 a result of it being high risk, there are certain 10 governance considerations that you consider are 11 particularly important, as you go on to list? 12 PROFESSOR WALSH: I think it's more of a for instance or 13 a for example than particularly picking out 14 neurosurgery. I'm sure Dr Gilder is probably better 15 placed than me to give a view about the specific risks 16 and issues in relation to neurosurgery. But what we 17 list there is a series of systems and processes that, at 18 that time, were kind of being introduced, were important 19 themes in the way in which services were managed and in 20 this transition towards -- I think it's -- the most 21 important bit of it is sub-point (a) towards corporate 22 accountability for clinical performance. And the idea 23 that organisations, not just at a board, health board or 24 trust board level, but also at a clinical directorate 25 level, would take greater responsibility. Page 166	1 be able to institute, maintain and demonstrate that 2 these systems are functioning properly? 3 A. It's the board's responsibility to make sure it is 4 assured. It's the non-executives especially who should 5 be seeking that assurance. It's the executives of the 6 board and the senior management team who should be 7 ensuring those systems are in place and working. And 8 what you would be -- hope to be seeing would be a board 9 who paid as much attention to issues of quality and 10 safety as it did to issues of operational and financial 11 performance. 12 Q. Okay. That, in many ways, is the essence of clinical 13 governance, isn't it? The movement away from it being 14 just a financial responsibility towards it being 15 a governance responsibility, as you've talked about? 16 A. Yes. 17 Q. Thank you. There was a couple -- in section 5, I think 18 maybe this is -- Professor Farrell, you had answered 19 this one, or that's as I have it noted. Again, you were 20 expanding on some of the things said in the previous 21 section that we have just been talking about as 22 important features of a proper healthcare system. And 23 we particularised this, again, to the field of 24 neurosurgery, but you talk here about something we've 25 already touched on, the move away from paternalistic Page 168

1 model, and focus here on something we've talked about in 2 a particular context of the importance of patient 3 involvement in decision-making. 4 I think we've talked about a number of these aspects 5 already -- 6 A. Yes, we have. 7 Q. -- but one aspect I just wanted to ask you about 8 particularly, which I don't think we've touched on, is 9 what you say at 5.1.5, which is at page 28. 10 PROFESSOR FARRELL: Yes. 11 Q. Again, this links into systems, we've talked about 12 adverse event reporting and that sort of thing but you 13 bring together the system and the involvement of the 14 patient here, I think, when you say that it's important 15 that there be open disclosure and institutional candour 16 and that: 17 "Following an adverse event, the importance of 18 patient involvement should extend to the investigation 19 phase. Affected patients or their representatives have 20 a right to be integrated into adverse event reviews, 21 provided with transparent explanations of causative 22 factors, and informed of implemented corrective 23 actions." 24 So I think that's an aspect we haven't quite touched 25 on yet, that where there are systems that are designed Page 169	1 different lenses when we examine a problem. The 2 patient's lens is probably the most important lens when 3 you try and understand what happened to them and their 4 experience. So it's fundamental. 5 And questions will come through the investigation 6 phase. If you do a proper systemic investigation, there 7 will be different elements of the patient's care and 8 a pathway that they will have followed and one would 9 investigate each of those elements. And so, having 10 patient involvement all the way through ensures that we 11 always know what the patient was experiencing at that 12 point in the pathway in question. 13 Q. And as a result, to use the phraseology that 14 Professor Farrell used, if the patient weren't involved 15 in the investigative phase it would perhaps be 16 inevitable that the investigation would fail because it 17 was missing that essential component at every stage? 18 A. Yes, it would miss the point. 19 Q. Thank you. 20 MR DAWSON: Sir, that would be a convenient moment for the 21 afternoon break. 22 THE CHAIR: Thank you. We'll take a 15-minute break and 23 resume again at 3.25. 24 (3.10 pm) 25 (A short break) Page 171
1 to try to pick up things that either may go wrong, 2 a near miss, or things that have gone wrong, be that 3 a single incident or perhaps a wider investigation, as 4 we have some experience of here, you're pointing out the 5 importance of patients being involved but particularly 6 in the investigative phase, rather than perhaps just 7 being told afterwards: we did an investigation, this is 8 what we've found. That the patients are involved, why 9 is that so important? 10 A. Well, I think generally we're talking about 11 an evolution, as we've spoken about, towards greater 12 patient involvement and recognising that and I'm happy 13 to talk about the evolution of the duty of candour and 14 the organisational aspect as well. But I would also 15 like to bring in Dr Gilder given her experience around 16 sort of investigations of these things from the -- 17 inside the hospital, so to speak, ward to board, to sort 18 of comment on the specifics of it? 19 Q. Yes. 20 DR GILDER: I think the most important point about patient 21 involvement is that without them, you don't have the -- 22 you're not really understanding what the experience was. 23 It's the patients' experience, it's the patients' care, 24 and that will not be reflected correctly by anyone but 25 the patient. And you have -- as you know, we all have Page 170	1 (3.29 pm) 2 MR DAWSON: Thank you, sir. One matter -- I think we've 3 touched on this in various different places, but I think 4 it might be helpful to bring this together. I think 5 this is a question that we asked of Professor Walshe. 6 I think at different times everybody has answered this 7 question but if we bring it all together it might help 8 people's understanding of different important concepts 9 here. 10 We asked you, in question 11, to give us 11 an understanding of the differences and perhaps 12 interrelations between corporate governance, 13 professional governance and clinical governance. I had 14 you down, Professor Walshe, as the person to answer that 15 question. And although we've touched on all these 16 concepts, it would be helpful I think for those who are 17 listening because these are phrases we've heard a lot, 18 to understand what these things are and how they all fit 19 together. 20 PROFESSOR WALSH: I'm sure you'll forgive me if I turn to 21 remind myself -- 22 Q. (Overspeaking) Yes, it is -- 23 A. -- what was said in section 11 -- 24 Q. Indeed, it's in section 11. We can go to that and put 25 it up and then elaborate -- Page 172

1 A. (Overspeaking) It's fine, I have it in front of me. 2 I think traditionally we thought of corporate governance 3 as being about the corporate performance of the 4 organisation; things we talked about earlier, 5 operational performance, financial management, targets 6 for delivery and so on. And we thought of professional 7 governance as being the system that made sure healthcare 8 professionals -- doctors, but also other healthcare 9 professionals -- were fit to practice and focused on 10 their professional responsibilities and so on. And 11 clinical governance has been the integrative mechanism 12 in bringing those responsibilities together, the kind of 13 umbrella. I think, if you go back to the clinical 14 governance papers, the circulars, but also the papers 15 written about it by Liam Donaldson and others, you will 16 see a series of kind of pillars that were set out, 17 I seem to remember the seven pillars of clinical 18 governance, which were meant to bring together the 19 systems and sources of information across the healthcare 20 provider to provide an integrated model of clinical 21 governance. Does that help? 22 Q. Okay, thank you. That's very helpful. I'll just 23 elaborate and bring in some of the things we've 24 discussed or we've heard about. So I think the idea is 25 that corporate governance was traditionally what the Page 173	1 responsibilities but before the period that we're 2 talking about, the 1990s, late 1990s, for the various 3 reasons and the various inquiries and developments and 4 thinking we've talked about, those two things were 5 rather separate, is that right? 6 A. Yes. 7 Q. Separate systems, if you like? 8 A. Yes, in parallel. 9 Q. But the idea of clinical governance was that the boards 10 would continue to have their corporate governance 11 responsibilities, running the health board, spending the 12 money wisely and justifying themselves to government, 13 but that there would be an innovation whereby they would 14 take a greater degree of responsibility for the quality 15 of what was going on within the hospital, which would 16 involve them becoming more involved in the oversight of 17 the activities of, amongst other things, doctors who 18 continued to have professional obligations, and indeed, 19 we've talked about how those professional obligations 20 have evolved and changed as well? 21 A. To have oversight but I think, in many ways more 22 importantly, to assure themselves that those systems of 23 oversight were in place and were working. So just as 24 financially they'd want to be assured, by their internal 25 and external auditors, that the financial systems for Page 175
1 likes of health boards did, is that right? 2 A. Yes. 3 Q. So they were responsible for making sure the money was 4 allocated to different departments and the financial 5 soundness of what was going on, in the same way any 6 other business might do, is that right? 7 A. Yes. 8 Q. And I think you mentioned earlier something we've come 9 across and you mention it in the statement that there 10 was, at a certain stage, something called the Blueprint 11 for Good Governance that was issued by the Scottish 12 Government, which tried to assist with that. It's just 13 at the end of paragraph 11.1. We heard a little bit 14 about this from a representative of the Scottish 15 Government yesterday that this was an innovation and 16 a further set of guidelines, but on the corporate 17 governance side, so was to do with the way in which the 18 board would be made up and the number of executives that 19 sit on the board and clarifying the functions of the 20 non-executives that we've touched on. 21 As we said, so that's corporate governance. What 22 we've been talking about for a large part of today is 23 a different system, whereby there had always been some 24 level of professional governance, so there had been the 25 GMC or other professional regulators that had had Page 174	1 making payments, for running payroll, for competitive 2 tendering and so on, all those procedures in their 3 financial procedure manual were being adhered to. That 4 doesn't mean that they do it themselves but they need to 5 be assured that those things are in place. In the same 6 way that they should be assured that the systems for 7 incident reporting, for appraisal and revalidation, for 8 reviewing untoward incidents and their systems more 9 generally, for audit and quality improvement were in 10 place, were working and were delivering impact. 11 Q. Thank you. One word that features around this area -- 12 it's actually in response to the next question, but 13 it's, I think, important too is, we asked you a question 14 about the developing principles that we've talked about 15 and you said: 16 "Since 1990 the structural evolution of clinical 17 governance across the UK represents a significant shift 18 in approach from largely unchallenged professional trust 19 to one of transparent, statutory public accountability." 20 Now, it's that accountability aspect I would just 21 like to ask you about, in this evolution that we've 22 described, the move from a more strictly corporate role 23 into the clinical governance and taking more 24 responsibility. 25 The statutory accountability that you're talking Page 176

1 about there, is that the statutory accountability that 2 applies to healthcare providers? 3 A. By "providers" do you mean organisations -- 4 Q. (Overspeaking) Yes, I do. 5 A. -- or do you mean individuals? 6 Q. I do. 7 A. Right. I mean, it depends on the statute and I'm not 8 a lawyer but increasingly what we've seen is embedded in 9 statutes or in secondary legislation, such as the 10 responsible officers regulation, rules which impose 11 duties on organisations and on individuals within those 12 organisations. 13 So I think the responsible officer role is 14 an interesting example of that. Those regulations 15 impose some duties on designated bodies, the 16 organisations, but also on the responsible officer as 17 an individual who is a regulated doctor and who, in 18 theory at least, you know, could be brought before the 19 GMC for not fulfilling their responsibilities as 20 a responsible officer. 21 Q. Yes, I think we touched on something earlier where 22 someone had not fulfilled their obligations as 23 an executive rather than as a doctor? 24 A. So the case that is often cited is that of John Roylance 25 who was the chief executive of the Bristol Royal Page 177	1 more accountable. 2 Q. That's perhaps why you say, in the footnote to this very 3 passage: 4 "Questions of accountability are not just confined 5 [to] healthcare ..."? 6 A. Yeah. 7 Q. Part of a wider societal trend? 8 A. Absolutely. 9 Q. Thank you. There are a few aspects that I'd like to 10 touch on that I think Dr Gilder has answered. One 11 aspect that we asked you about was to do with practising 12 privileges, in particular, and you told us a lot about 13 the revalidation and appraisal system. One aspect I was 14 keen to try and explore with you was we've heard about 15 practices privileges in some of the evidence that we've 16 discussed but particularly in the context of private 17 practice, there being a need to have practising 18 privileges in a private hospital. One aspect I was 19 interested to explore with you was the extent to which 20 there is a system, or should be a system whereby the 21 extent of the different services that, say, 22 an individual consultant offers is regulated or should 23 be regulated in some way by the hospital authorities, to 24 put it broadly, in an NHS hospital? 25 DR GILDER: Yes. Page 179
1 Infirmity and a radiologist by background and who was 2 taken to the GMC and struck off for his failures as 3 a chief executive in the really rather sorry saga of the 4 way in which problems in paediatric cardiac surgery were 5 ignored and dismissed over quite some time. 6 Q. But the words "responsibility" and "accountability" have 7 come up a lot in the evidence that we've heard and so 8 I was just keen to bring that into this evolution that 9 we've discussed. Because I think it is an important 10 part of this, that -- that sentence describes a move 11 from professional trust, assuming doctors were doing 12 everything that they need to be doing, and imposing 13 an accountability through professional governance on 14 them but also on the organisations themselves. That 15 accountability is an obligation that is imposed upon the 16 executives as well as part of this movement, is that 17 right? 18 A. Yes and I would situate that in a sort of wider, 19 societal trend towards holding public institutions more 20 explicitly to account, whether they are schools and 21 teachers, whether they are lawyers and law practices, 22 whether they're prisons or police forces. You know, 23 that shift towards what, I think in one of our 24 references, Michael Power's book, was described as "the 25 audit society", in which organisations are explicitly Page 178	1 Q. Yes, and so, for example, if -- we talked earlier, you 2 talked about the concerns that one should have if 3 a consultant was appointed and issues came up later and 4 all the problems that would be experienced and the 5 importance of that decision. I think that was 6 associated, to some extent, with the responsibilities of 7 a consultant but also with the freedom that a consultant 8 is afforded. And I was interested to understand whether 9 it is a matter for a consultant to choose, for example, 10 which -- again, if we put it in the field of surgery, 11 which surgeries he or she offers to patients, or whether 12 that's a matter to be regulated in some way by the 13 hospital or hospital authorities? 14 A. So when you apply for a consultant role, you are -- the 15 process is that there is a job description that you are 16 applying for. And within that job description it 17 describes your duties and in the context of neurosurgery 18 that would be quite specific about -- and I know you 19 heard from two neurosurgeons, one who has a cranial 20 practice and one who has a spinal practice. So within 21 a job description, the hospital would be looking for 22 a surgeon expertise in spinal surgery. So the 23 expectation is that I would apply for a job with -- and 24 I would be able to demonstrate the skills that are 25 required by the job description. And so it wouldn't be Page 180

1 up to me say: oh, I don't want to do that any more. 2 That would be a job planning negotiation I would have 3 with my clinical director if I wanted to change my 4 sessions or do something different. 5 Q. Rather than a job planning type issue around how many 6 theatres sessions had and how many clinics you're doing 7 and hours and things like that, we've heard, within the 8 field of neurosurgery, about something called 9 "sub-specialties" and the fact that, although broadly, 10 intracranial work or spinal work would be the sort of 11 thing that one -- there would be certain things one 12 would have to demonstrate a competency in to be able to 13 get on the specialist register and those are the sorts 14 of things that one might have to do if one were on-call, 15 any patient might walk in with those sorts of problems 16 and so you would have cover them, if I can put it that 17 way. But what about the other elements, what we 18 understand are called sub-specialties, things that are 19 bit more -- that certain people would do and others 20 would not? And is there a conversation that happens 21 around those with regard to which surgeries are offered 22 or is it a matter for the consultant to decide -- 23 A. (Overspeaking) No, it's an expectation. So many 24 consultant jobs are advertised as sub-specialties posts. 25 Mine, for example, which was transplant anaesthesia. Page 181	1 last 15 years. So we have had -- there are, throughout 2 the UK surgeons who practice urology, a group of them 3 have gone and learnt how to do their surgery through 4 a robot. So that would be an evolution of practice 5 so -- which would not be a requirement, but it would, 6 because what you're doing is you're developing -- you 7 are becoming -- best practice as the right operation for 8 a prostate, for example, which, in many cases now, is 9 a robotic approach. 10 MR DAWSON: So in that hypothesised situation, the doctor 11 would become interested in that, would be trained in 12 that, would have to develop some sort of technical 13 competence. But would there still need to be 14 a conversation, if you like, with the hospital 15 authorities, the clinical director, as to whether the 16 surgeon or the doctor was going to be allowed to offer 17 that service? 18 A. Yes. 19 Q. And what sorts of considerations would be part of that 20 discussion? 21 A. So if you're doing -- assuming this is a new approach to 22 surgery, you would have to have a business case because 23 you need skilled individuals to support you, you need 24 the right sort of resources to -- you need to look after 25 the patient -- in a robot, for example, you need to buy Page 183
1 That is a very narrow specialty, it's a sub-specialty, 2 and I had to demonstrate I had the skills for that 3 particular -- so, the hospital has, as you know -- 4 provides a range of services and consultant jobs are 5 advertised where they have a gap. And within that job 6 it describes exactly what you'd expect, be it specialty 7 or sub-specialty, in terms of what you would actually be 8 expected to be doing with your time. 9 THE CHAIR: Is there a difference between an expectation and 10 a requirement though? What I think -- certainly, what 11 I would be interested in understanding is if -- possibly 12 not as the contemporary world, but if there's been 13 a time where things morph into something different. So 14 you apply for a job against certain expectations as to 15 what that would be and that's set out in a job 16 description, but the nature of the practice develops, 17 perhaps in an informal way, with the result that you end 18 up doing a wider scope of surgery than the expectations 19 of your job description merited? 20 DR GILDER: So the requirement would be that you would be 21 required to carry out the duties of your job -- of the 22 job description that you were appointed to. That would 23 be a requirement. However, over a 35-year career, you 24 may develop a specialist interest. You may go -- like 25 robotic surgery is a really good example, new in the Page 182	1 a robot, et cetera, et cetera. So actually expanding 2 your service requires -- and really, at the moment in 3 a massive way, a business case to change your practice. 4 And you need to demonstrate a need, demonstrate its 5 value for money, never mind the quality and safety 6 elements of this type of service. You wouldn't -- if 7 it -- there have been cases where the "a single 8 practitioner approach": I want to do this, no one else 9 does it in the hospital. And it's very unwise to build 10 a service around an individual. What if they go on 11 holiday? They can't cover 24/7, 365, et cetera, 12 et cetera. Is that actually a safe approach to bring 13 something in? 14 So for robotic surgery, for example, you'd have 15 a number of surgeons being trained at the same time if 16 you were going to investment in a robot and they would 17 have a comprehensive service which would be covered by 18 a group not an individual. So there certainly is a risk 19 of an individual going off and particularly bringing in 20 new procedures. 21 Q. Thank you. To try to look at it more in the historical 22 context, has that broad discussion always been part of 23 the way that hospital consultancy works? If you want to 24 do something that's outwith the basic skills in the job 25 description, if I can put it that way, that you would Page 184

46 (Pages 181 to 184)

1 have to have a dialogue as to whether that service 2 should be offered and all of these considerations would 3 have to be taken into account? It's not for the 4 consultant themselves to make that decision; is that 5 right? 6 A. So it's interesting. So you've used the word "should" 7 over the course of today. 8 Q. Correct. 9 A. It should have been a discussion, it isn't always 10 a discussion. Hasn't -- in the past, hasn't always been 11 a discussion. 12 Q. That's very helpful, thank you. So a couple of other 13 aspects to touch on that I think are with you, 14 Dr Gilder. We talked earlier briefly about the 15 importance of the processes that should be gone through 16 when giving a consultant a job and you reflected on some 17 of the current practices and your views on that. One 18 other aspect that you specifically helped us with in 19 question 8 was in relation to information that would be 20 available and would need to be assessed, in particular 21 in a situation where a doctor were applying from abroad, 22 where, therefore, there might be a situation where the 23 information that was being presented might not be as 24 familiar as the sort of information that would be 25 presented with a doctor who had perhaps come through the Page 185	1 earlier about the importance of making sure that if 2 you're appointing a consultant you know exactly whom 3 you're appointing, you'd expect that the system would 4 require medical degrees, specialist diplomas and any 5 other licences to be checked by the GMC? 6 A. Yes. 7 Q. Thank you. Another thing I think you touched on 8 earlier -- I meant to ask you about it but I didn't come 9 back to it. You mentioned, later in that same 10 paragraph, something called an "international 11 certificate of good standing". I think you touched on 12 it earlier. "Good standing" is something that's come up 13 in the evidence we've heard before, but I think maybe 14 this is using it in a different context. We heard about 15 it in the context, a bit more historically, to do with 16 Royal Colleges and whether someone was in good standing. 17 And we established that, in fact at one stage, it pretty 18 much meant little more than having paid one's dues to 19 the Royal College. I think perhaps this may mean 20 something more but if you could explain what 21 an international certificate of good standing would 22 comprise? 23 A. I think this is historical and this is an expectation 24 whereby a doctor who has not been trained in the UK gets 25 a certificate from their previous hospital, saying: we Page 187
1 United Kingdom system. And I think you told us, in 2 paragraph 8.1.1, if we could just have a look at that. 3 You told us that: 4 "Key principles for the appointment of consultant 5 surgeons, including international and competency 6 verification, should include the following ..." 7 And one aspect, under 8.1.1, you say: 8 "The assessment and verification of foreign 9 qualifications or surgical practices ..." 10 And you say, in the third line from the bottom, 11 that: 12 "The regulatory system mandates direct, independent 13 verification of medical degrees, specialist diplomas and 14 licenses directly from the issuing international 15 University or Ministry of Health (historically managed 16 via international credentialling services or directly by 17 the national regulator, such as the GMC) ..." 18 So what was it that was meant there by "direct 19 independent verification"? 20 A. That means that the GMC would be presented with those 21 certificates; they are the independent verifiers. So it 22 wouldn't be me, as the employer, Dundee, for example, 23 verifying it. It would be the GMC which is 24 an independent regulator. 25 Q. And you would expect, for the reasons you explained Page 186	1 left in good standing with you. I have been asked to 2 provide such certificates for clinicians I don't know 3 and don't know their practice and refused them. So they 4 still exist, but it -- I'm not sure how much value they 5 actually add, as you're implying. I think what's much 6 more value in terms of the CESR process and the 7 portfolio process, is the evidence and it's a huge 8 amount of evidence that these individuals have to supply 9 about actually what they did, what the competencies 10 were, workplace assessments, audits they've done, 11 et cetera, add much more value than a certificate of 12 good standing. 13 Q. Understood. 14 A. They're still required, but -- 15 Q. Yes. There is a lot of evidence, as you say, that you 16 narrate for us here and I think you're telling us that 17 perhaps some of the other evidence is more crucial to 18 the success? 19 A. With the exception of these international -- I mean, 20 I haven't seen an international certificate as they 21 wouldn't come to me, they would come to the GMC. But if 22 these individuals had been in the middle of disciplinary 23 procedures, et cetera, you would expect to see that on 24 the certificate of good standing, but I couldn't say to 25 you what the quality of the information that those Page 188

1 certificates actually stand for. 2 Q. Understood. And in the event that -- obviously, you've 3 gone through a whole raft of important information that 4 requires to be considered -- would one be trying to 5 access, in a circumstance where someone is applying for 6 a consultancy, as much information as one possibly 7 could? In the same way as we were talking about earlier 8 accessing and triangulating as much as evidence as one 9 could within a hospital, is it really a question of 10 trying to access as much reliable information as one can 11 to make as good a decision as one can? 12 A. So, from the perspective of an appointment committee, we 13 have total reliance on the GMC to do this process. 14 Q. Right. And would it be important, if someone had 15 an international component to their background, in 16 particular if that were recent working abroad 17 experience, that you had can access to information about 18 working abroad recently? 19 A. So that hasn't been something that I've had to deal with 20 ever. I would say that when we have such doctors 21 applying for roles, we would offer them a year's type 22 fellowship role, to -- because it's all very well 23 knowing how to do the surgery but working in a UK system 24 is very different and you are immediately putting that 25 doctor at risk by appointing them into a consultant role Page 189	1 our own, they come from Egypt and India. And first of 2 all, there's a considerable cultural difference and 3 we've done -- I have quite a lot of experience of how 4 we've worked in a culturally sensitive way with 5 individuals. 6 So, for example, in a group of doctors where their 7 training doesn't cover end of life care and end of life 8 care is against their faith and yet here, end of life 9 care is a really, really important practice of caring 10 for patients at the end of life. So that is one of the 11 best examples I can give you around the difference. And 12 there is also a difference in hierarchy. 13 So we are a much less -- although it might not feel 14 like it, we're a much less hierarchical medical system 15 than, for example a doctor trained in Egypt. Whereas 16 a senior doctor in Egypt would not expect to be 17 challenged by a junior member of the team and may not 18 react in a particularly favourable way because that is 19 the culture in which they were trained. So there is 20 quite a lot of cultural sensitivity when you think about 21 hiring people from, not Australia, not New Zealand, not 22 Canada, but some of the areas where we do actually hire 23 doctors from. 24 Q. Understood, and nowadays that would be an important 25 part -- Page 191
1 and the organisation at risk and the patients at risk. 2 So I have never been in a situation whereby we have 3 appointed someone from abroad in either of the two 4 hospitals where I was a consultant without them actually 5 having spent a year with us, or more -- you know, if you 6 like, we're giving them a fellowship to understand the 7 fit the organisation and their skill level. It is 8 a quality assurance process. 9 Q. It's sort of a probationary period? 10 A. It is a probation, it absolutely is. In fact, I was 11 employed -- I was employed on that basis in Cambridge, 12 first of all, not because -- because that's how you got 13 consultant jobs at Cambridge, you did a fellowship first 14 and they tested you out to see whether you are a fit for 15 the organisation. 16 Q. Understood. And the phrase you used I think was working 17 in the UK is "very different" there? 18 A. Yes. 19 Q. What did you mean by that? That the standards are very 20 high, or ... 21 A. So I think it depends on where -- if you compare to 22 where you're coming from. But even our colleagues who 23 might come from, say, Australia or New Zealand, would 24 describe it as different. But most of our international 25 medical graduates don't come from similar countries to Page 190	1 A. Really important. 2 Q. -- of trying to make sure that someone would fulfil the 3 role and integrate properly within the way the hospital 4 works? 5 A. Correct. 6 Q. Understood. One aspect of that -- you talked -- I think 7 you say, at paragraph 8.1.2, again, that: 8 "The transition to independent consultant status 9 requires definitive proof of technical mastery and safe 10 clinical decision-making." 11 And you talk about the GMC equivalence process which 12 I think you've touched on. One aspect that I was 13 interested in just exploring with you was the extent to 14 which, if someone has worked abroad, it's entirely 15 possible, in the surgical field in particular, that 16 although they may have been working at a high level of 17 competence, that the techniques or the way in which one 18 might go about things may be different. It may be, for 19 example, they used different equipment or they have 20 different radiology or something like that. Is it 21 important that there be a careful assessment, even if 22 someone is an excellent candidate based on all the 23 information, as to precisely what techniques they had 24 been using, to make sure they fit in with what you call 25 the UK system? Page 192

1 A. Yes. Yes. And again, this goes back to my point 2 about -- I have not had experience of hiring 3 an individual without having them done time in the 4 NHS -- in a previous role within the NHS or in my own 5 organisation in the NHS, in a non-substantive role. 6 I think most organisations appreciate there's a huge 7 risk employing someone who is not familiar with the 8 National Health Service into a substantive role. Huge. 9 Q. Thank you. Would it always be the case, in any 10 circumstances, that you would want to know what someone 11 had been doing in they applied for a consultant post in 12 the most recent period, so say in the last year or two? 13 A. Yes. 14 Q. Because that would be -- 15 A. Yes. 16 Q. No matter what they had been doing, it would be relevant 17 to the job? 18 A. Always. 19 Q. And so you'd be interested in finding out anything you could 20 about that? 21 A. Yes, and you would expect them to provide that 22 information in their curriculum vitae, in the job 23 application, in the pre-interview visits and within the 24 interview themselves, if you short-listed them. 25 Q. Thank you. If someone who had had -- as may well Page 193	1 DR GILDER: You are not meant to do that, because of 2 bias -- it becomes then not an open competition. It 3 introduces bias into the -- what you can do is hope that 4 people come and say: oh, I know this person, they're 5 really good. But me, if I was on an interview 6 committee, I'm not actually allowed to ring up 7 organisations and say: what do you think of this person? 8 MR DAWSON: That's the theory. Does that actually happen? 9 A. I always took it very seriously. I was concerned if it 10 found out, it would introduce bias and I could be taken 11 to task for that. 12 Q. Understood. 13 A. I mean, it wasn't something -- we used to do that. That 14 used to be the practice, absolutely. But it is not 15 part -- it is not currently acceptable practice. 16 Q. So again, you've helped us out with historical 17 evaluation of things and when you say it used to be the 18 practice, might it have been the practice towards the 19 beginning of the relevant period that we're looking at? 20 A. Yes. 21 Q. Yes, you would expect someone to phone up somewhere 22 else, a local hospital or something, and say: we have 23 someone who is applying for a job -- 24 A. Yeah, old boys' network. 25 Q. -- they worked for you apparently and would you give Page 195
1 happen, I'm sure it does -- an international employment 2 history where they'd worked in various different places, 3 including in the UK, if they had claimed to have some 4 local experience working in a hospital that would be 5 nearby or would be familiar to you, would that be 6 somewhere where you'd want to have information from 7 because you might rely on them to know whether they 8 could fit into the UK system? 9 A. So you'd expect -- the first reference of anyone that is 10 applying for a job, their first reference is from their 11 most recent employer and the usual process is to send 12 that employer a structured form asking particular 13 questions. It's fairly generic -- a fairly generic 14 form. 15 Q. Right, yes. But if someone had worked locally, so say 16 for example, if the employment history said that someone 17 is applying for a job in Edinburgh or something like 18 that and someone had worked in Scotland before, would 19 that be something that you would want to interrogate 20 because that might give you some useful information 21 which might not be revealed by someone who had worked 22 elsewhere in the UK or abroad? 23 A. So we're not actually supposed to ring around and find 24 out about that. 25 THE CHAIR: Sorry, you are not meant to? Page 194	1 them a job? 2 A. Yes, absolutely. There was plenty of that. 3 Q. Thank you. One other aspect you helped us with which is 4 connected to this area and particularly the idea of 5 giving someone a sort of probationary position as 6 a clinical fellow, we asked you what your expectations 7 would be around induction of consultants and you 8 provided us with a very detailed and helpful breakdown 9 of all of the various things. In fact, when we were 10 reading it, there were lots of things you think: oh, of 11 course, you would need to know about that as well. 12 A. Yes. 13 Q. I think it fair to say, overall, Dr Gilder, in your 14 response, which goes on for several pages about various 15 different things -- 16 A. Sorry. 17 Q. No, it's extremely helpful, the inductions for 18 consultants are very important? 19 A. They are. 20 Q. Yes. In particular -- and you go through lots of 21 different aspects of what's important -- in essence, one 22 of the things broadly that one needs to understand in 23 an induction is the way things are done locally? 24 A. That's right. 25 Q. Is that right? Page 196

1 A. That is right. 2 Q. Because you might have worked in lots of different 3 hospitals and you might have done lots of different 4 surgeries but what's essential is that you understand 5 the way it's done in this hospital so you integrate 6 properly, is that right? 7 A. That is exactly right. 8 Q. So you mention, as a number of examples here -- of 9 course there would be practical things you would need to 10 know, how to switch the computer on and things like 11 that, but there would be, if you're a surgeon, for 12 example, things about how we go about doing our 13 mortality and morbidity meetings in this hospital. 14 A. Correct and what the expectation is about attendance. 15 Q. Absolutely. Similarly, multi-disciplinary meetings -- 16 A. Yeah. 17 Q. -- which are very important, how we do that and how you 18 can integrate into the system, is that right? 19 A. Yes. 20 Q. And I think there are also other aspects that are not 21 necessarily related to clinical practice, but related to 22 some of the governance issues that we've discussed. So 23 for example, making sure that someone is aware of what 24 adverse incident reporting systems are used, is that 25 right? Page 197	1 themselves can decide: is this a unit in which I feel 2 comfortable? 3 A. Exactly. 4 Q. Thank you, that's very helpful. One other specific 5 aspect that we're interested in looking at in this 6 Inquiry, which I think maybe all of you have an input in 7 but it's more of a clinical thing, relates to the way in 8 which, when there are concerns, or when there are issues 9 with someone's practice -- which I know you've had 10 experience with in some of your roles, Dr Gilder -- how 11 the system should go about making decisions around what 12 one should do about addressing that. In particular, 13 we're interested in looking at systems which may exist 14 within a hospital for putting someone under clinical 15 supervision. 16 Now, this is of particular interest to us and 17 I'd certainly be interested to know what sort of 18 systems, if an issue had arisen, went through the 19 governance systems, and there had been complaints or 20 there had been an adverse event review or something like 21 that, that said: there's an issue with this surgeon or 22 doctor, what sort of process would be gone through to 23 decide what should be done? What sort of -- I don't 24 want to use the word "discipline", but I suppose what 25 sort of disciplinary measures might be most appropriate Page 199
1 A. Yes. 2 Q. What the expectations around complaint systems would be? 3 A. Yes. 4 Q. What the systems would be for the way in which local 5 duty of candour protocols function? 6 A. Yes. 7 Q. All very important stuff. And as you have told us, many 8 more things that are essential, including understanding 9 the details of the theatre environment? 10 A. Yes. 11 Q. The way in which teams in theatre are composed, the 12 availability of other staff and their functions? 13 A. Yes. 14 Q. All of these things. It rather tends to suggest that 15 this induction is not something that one might expect in 16 normal jobs, but it would be an elongated process of 17 education? 18 A. Yes, it is quite a long process, yes it is. Yes. 19 Q. And in many ways, I think that's consistent with what 20 you said earlier about the practice in some hospitals 21 and in your experience, of offering someone a clinical 22 fellowship for a year so that not only can they, if you 23 like, prove themselves that they're able to do the job 24 but that they can develop, over that year, the 25 understanding of the way things work so that they Page 198	1 to take in the circumstances? 2 A. So I'm just going to start at the beginning because it's 3 a helpful chronology. So there is a concern raised. 4 The concern is investigated locally within the hospital. 5 If there is a concern about competence, it goes outside 6 of the hospital at that point. So, as a responsible 7 officer, I would be discussing that with the GMC, 8 employment liaison advisor, and there would be 9 discussion about whether it meets the threshold for 10 referral to the GMC. 11 And the other organisation you bring in immediately 12 is NHS Resolution or the PPAS, the practitioner 13 advisory -- Practitioner Professional Advisory Service. 14 And actually. 15 Q. That's something we've not come across. Is that 16 something to help the doctor? 17 A. No -- well actually it's a fantastic organisation. It 18 helps the organisation, it helps -- it's supportive for 19 the doctor. Its approach is quite compassionate. It's 20 about how do we support the doctor to improve, it's not 21 how do we discipline the doctor. 22 So each hospital has a relationship with a member of 23 that organisation. That individual in that organisation 24 is often a fully trained and very experienced senior 25 clinician and that individual will then support me as Page 200

1 the medical director to effectively ask the right 2 questions and consider different routes of remediation 3 for the colleague. And it is absolutely expected as 4 part of any disciplinary process that you have consulted 5 with them, and they have given you advice and you have 6 it in writing. 7 Now then can actually just put together clinical 8 supervision processes because often -- you might 9 understand it might be quite difficult within the 10 organisation for that individual to have the supervision 11 within the organisation because I think it's quite hard 12 to work with people who have had poor practice and that 13 often impacts on the team around them. And the 14 individuals themselves might also not feel comfortable 15 being supervised within the organisation. 16 So through a combination of a GMC conversation and 17 perhaps a process and definitely an NHS Resolution, we 18 would think about what is the appropriate supervisory 19 process for the individual. 20 You might also involve the Royal College for that 21 particular individual. And I have certainly known it 22 where individuals -- I have not had to do this myself -- 23 but individuals in an organisation in which I've worked 24 before were actually supported and supervised in another 25 organisation to build their practice up. Page 201	1 that investigation you go to the GMC with your findings. 2 But in the meantime I will have informed the GMC that 3 we're doing the investigation. 4 Q. Understood. So there will be intimation and 5 information -- 6 A. (Overspeaking) If there's a conversation, almost 7 immediately. As soon as you started disciplinary 8 process on a doctor, your employment liaison advisor, 9 you make them aware of that. 10 Q. And what sort of concern would trigger this situation? 11 We talked earlier about the importance of a near miss 12 aspect to an adverse incident management system in order 13 to try to be preventative and make sure that anything 14 didn't depend on there being actual harm caused. Does 15 that principle apply here too? 16 A. So if you are going to invoke the maintaining high 17 professional standards framework, as soon as you embark 18 on that the GMC needs to be informed for any doctor. 19 Q. And what would trigger that being instigated? 20 A. Well, I think you know there are four areas that are 21 investigated, through MHPS: one is probity, one is 22 conduct, one is capability, and one is health. 23 Q. Understood. 24 A. So it could be across any of those four domains. 25 Q. Thank you. Sorry, Professor Walshe. Page 203
1 But it's all documented. It's all recorded. There 2 are expected stages of that process, which is 3 a combination between NHS Resolution, GMC and the local 4 employment. 5 And of course this doesn't stop you, if there is 6 harm et cetera, there's a whole set of processes around 7 that investigation. 8 Q. Okay. Just on one -- I'll come to you in a second 9 Professor Walshe, thank you. 10 Just on one aspect of that. You mentioned the 11 importance of investigation, there being a local 12 investigation in certain circumstances but then there 13 being I think an obligation to take it outside the 14 organisation at a certain point. Two questions about 15 that. One is if an investigation is started, is it 16 important that it runs its course? 17 A. Yes, I would say so. 18 Q. And this may be a difficult question to answer 19 because it's a matter of degree, I'm assuming. At what 20 point does that obligation kick in to make something -- 21 to involve external agencies like the regulator? 22 A. No, the GM -- well, I think it depends on the severity 23 of harm. Well, no, not "I think", it depends on the 24 severity of harm. But the expectation from the GMC is 25 you do the local investigation and when you have done Page 202	1 PROFESSOR WALSH: I just wanted to come in on the subject 2 of the GMC's employment liaison advisors. That's 3 a reform that was introduced around the same time as the 4 requirement for revalidation and it addressed a problem 5 that for medical directors in NHS organisations the 6 process of referral to the GMC in the past had been 7 a rather distant one in which they would complain that 8 they made a referral and they didn't know what was 9 happening about it, it would go off to the GMC, they 10 weren't sure whether they were making the right 11 referrals, and they got very poor feedback. So the ELAs 12 were appointed. And each of them, relatively 13 experienced GMC officers, have a portfolio of 14 organisations, both NHS and non-NHS designated bodies. 15 And they established links with them, they visit them, 16 and they are available to have discussions about cases. 17 And in our research on revalidation, actually 18 responsible officers very highly valued the introduction 19 of the employment liaison service and said it had 20 changed their relationship with the GMC and made them 21 much more able to make effective referrals and also 22 to -- a source of advice on cases where there was 23 a decision about whether to make a referral. 24 On the practitioner performance advisory service run 25 by NHS England, I'm not clear whether that's Page 204

1 an England-only initiative or a UK one. 2 PROFESSOR FARRELL: Mention was made of NHS Resolution, and 3 that is an England body. But the principles are more 4 broad in the sense that from the mid-1990s onwards there 5 was an increasing centralisation of the defence 6 initially of medical negligence or clinical negligence 7 claims. So NHS Resolution was previously known as the 8 NHS Litigation Authority. So where things had been 9 decentralised, they increasingly were centralised under 10 Litigation Authority, and then over time it's been 11 renamed as NHS Resolution. But the data they were 12 gathering and in terms of risk management and general 13 performance of both individual clinicians and different 14 sorts of doctors and healthcare professionals has 15 expanded rapidly, and so there's a lot more involved in 16 sort of risk management as well as just obviously 17 clinical negligence claims being an aspect of that. 18 And obviously Dr Gilder would have more experience 19 at the coalface of that. 20 DR GILDER: I didn't know they were not in Scotland, so 21 forgive my ignorance. 22 Q. Not at all. 23 A. And if you have team dysfunction, you can bring them in 24 to do mediation et cetera. You can bring them in early; 25 they're quite good early intervention people. Lots of Page 205	1 as the approach to just culture to really try to 2 understand the system. Because you're very much part of 3 a system when you deliver healthcare and it can often be 4 system factors that have set you up to fail rather than 5 your individual failure. 6 So, yes, when I used the term investigation, I don't 7 use it to imply punishment, I use it to imply 8 understanding what went wrong and what were all the key 9 components to that, and then using a systematic safety 10 science-based approach to unpick those things. And then 11 where -- if you find that there is an opportunity to 12 support the clinician in any particular way, then that 13 opportunity needs to be taken. 14 Q. And I think we may have touched on this already but in 15 these sorts of circumstances is early intervention 16 an important principle? 17 A. Very. 18 Q. Because early intervention may reveal the reasons that 19 may on the face of it suggest, oh, the doctor has made 20 a mistake or something, but in fact it may reveal there 21 are other elements of support we can get back to the 22 original position. So is that an important part of the 23 thinking? 24 A. Very important, particularly in behaviours. And we call 25 it the "cup of coffee conversation". Documented. The Page 207
1 wisdom, lots of experience, and they have the type of 2 resources that you might not have in a -- particularly 3 in a small district general hospital in terms of 4 mediation, bringing teams together, et cetera. 5 MR DAWSON: I think it would be important, from something 6 you said earlier Dr Gilder, that it would be important 7 in these sorts of circumstances, based on the various 8 different reasons why one might have concerns, for there 9 not to be any assumption that in some way if something 10 has gone wrong or there's a near miss that it is in some 11 way the fault of the doctor in question. Part I think 12 of the just culture approach that you and others have 13 talked about in the report. Because it may well be, in 14 fact, that if things are going wrong or there are signs 15 that what is required is not disciplinary action in 16 terms of punitive disciplinary action but support and 17 training and help, which may ultimately be the solution 18 for getting better patient care? 19 A. Correct. 20 Q. Understood. So in those sorts of situations perhaps 21 mediation is part of trying to achieve that? 22 A. So the approach to any investigation is a just culture 23 approach now and it very much starts with: no one comes 24 to work to do a bad job. It very much starts there, and 25 then there's a series of questions or tests that you ask Page 206	1 end of the conversation is, "If this happens again, 2 we'll go through a disciplinary process." But that 3 early intervention is to say this is unacceptable. 4 That's usually enough. 5 Q. Understood. Thank you. Just to touch on one point, 6 Professor, that you raised was about the employment 7 liaison advisor. Just to be clear, you said, I think -- 8 we have some particular reason to understand that the 9 ELA I think came in around 2012. Just to clarify that 10 the advantages that the responsible officers identified, 11 was it largely around the fact that there could be 12 a dialogue with the ELA in any circumstances, ie whether 13 there was a problem or there wasn't a problem, but if 14 there was a problem, they could be given advice which 15 may have been difficult to achieve if the GMC were more 16 distant as it had previously been? 17 PROFESSOR WALSH: Yes. I think the reforms to the GMC and 18 introduction of revalidation in many ways created 19 a system of professional regulation that is, in part, 20 delivered by employers, and that was a really 21 fundamental change. And the ELAs and their appointment 22 provided a new communication channel I think for the GMC 23 itself in understanding, you know the challenges and 24 problems of responsible officers in dealing with 25 concerns about performance, but for responsible officers Page 208

1 and medical directors and others a channel to the GMC 2 and a named individual to whom they could speak. 3 Dr Gilder has practical experience of dealing with 4 the ELA and she might want to say more about the extent 5 to which you could share concerns informally with your 6 ELA and the point at which that becomes something that 7 you and/or the ELA are writing down. 8 DR GILDER: Exactly. So that conversation is always 9 documented, it's recorded, including the GMC number of 10 the individual you're talking about. So that is 11 something -- and subject to freedom of information 12 requests. So if somebody had had a conversation about 13 me with an ELA, I can get that entire conversation from 14 the GMC with an FOI. So when we have those 15 conversations, first of all the ELA reminds you of that. 16 So when I was at the beginning of my medical 17 director career, they were very helpful in terms of 18 these are the rules, this is what happens in these 19 conversations. That did not stop me asking for advice 20 but you need to be mindful of saying -- giving correct 21 information in the correct context. And I did discuss 22 concerns that never proceeded any further but it was 23 important to have their take on it. 24 Q. A couple of things, one arising out of that, one 25 separate but comes up at this moment. One aspect of Page 209	1 someone who was in the organisation two years ago and my 2 advice was not to allow voluntary erasure. 3 Q. Why might you do that? It might seem odd -- 4 A. Because I knew that this individual was likely to seek 5 work abroad, because they already had. 6 Q. I see. 7 A. And I was concerned that if that individual got 8 voluntary erasure then everything that was going on, in 9 terms of the GMC investigation, would no longer be 10 visible to an employer from another country. That's why 11 I said that. If they were 80 it's different. 12 As I say, Professor Walshe knows much more around 13 the variety of circumstances as to why you wouldn't. 14 Q. Thank you. Yes, please, Professor? 15 PROFESSOR WALSH: I'm sure you will have the opportunity to 16 ask people from the GMC about their policy on voluntary 17 erasure. 18 Q. We've done that already. 19 A. Oh you have. Okay, well tell me if I say what they say. 20 I think it is an area of real concern and contention and 21 I think the main concern is that doctors might use the 22 process of voluntary erasure to evade a process of 23 accountability for their behaviours or performance. 24 In practice there's two forms of that erasure, 25 there's voluntary erasure and administrative erasure. Page 211
1 things we've been looking at and the group was asked 2 some questions about was the rules that relate to 3 circumstances in which somebody wishes to remove their 4 name from the GMC medical register voluntarily. And 5 we've heard some evidence about the systems that would 6 be used in order to try to contact current or recent 7 employers about that application. And I think it is 8 you, Dr Gilder, who has addressed this question in the 9 report. 10 Broadly speaking, without getting into the details, 11 in those sorts of circumstances, what are the 12 obligations of an employer or a recent employer to 13 engage with an application for voluntary erasure? 14 DR GILDER: So I will say that Professor Walshe actually 15 wrote this, but -- so the form you are sent from the GMC 16 is called the SD8 form, and it is a form where the 17 clinician is making a request for voluntary erasure and 18 you are asked whether there are various things like any 19 ongoing disciplinary proceedings, ongoing concerns 20 et cetera and you declare that on that form. You are 21 also able to make a recommendation that you wouldn't 22 recommend for voluntary erasure. But the GMC do not 23 have to -- I'm going to hand over to Professor Walshe 24 because he understands the chapter and verse on this. 25 But, in fact, recently I was consulted about this on Page 210	1 So if it's a doctor, you simply stop paying your 2 registration fee. The GMC, after a period of trying to 3 find you and get you to respond, will remove you from 4 the register. 5 Voluntary erasure is where you apply to be removed 6 and it's probably commonest at the point of retirement 7 or post-retirement and it can be a perfectly acceptable 8 thing to do. 9 The GMC's guidance. Well, the guidance is operated 10 by GMC case examiners, unless there is an ongoing 11 tribunal in which case the -- because you can apply for 12 voluntary erasure during a medical practitioner's 13 tribunal. Unusual, but it does happen. But it's 14 a decision made by case examiners. And the guidance, 15 which I would paraphrase, says that the case examiners 16 have to weigh up the potential risks of allowing 17 voluntary erasure and particularly consider whether the 18 person might seek to return to practice, particularly 19 outside the jurisdiction of the GMC, but also to 20 consider the public protection arguments and make 21 a judgment if there are ongoing investigations about the 22 seriousness of harm that is being investigated in those 23 investigations. 24 It's a really contentious and challenging area and 25 the concern I think from many people would be that it's Page 212

1 a mechanism by which somebody could evade scrutiny. 2 Q. Yes, understood. And as we've encountered in other 3 areas, it would be important in a situation like that, 4 in order to make the right decision, that one had access 5 to all of the relevant information; is that fair? 6 A. Yes, it is and I wanted to make one other point that 7 relates to that discussion. The GMC regulates doctors, 8 it doesn't regulate healthcare providers. So it has 9 statutory powers to require healthcare providers to 10 provide information, but it doesn't have statutory 11 powers to require healthcare providers to provide 12 information. Similarly it is not the owner of the 13 responsible officer regulations, that is the Department 14 of Health and Social Care. So its powers are shaped by 15 its regulatory remit. For example, it doesn't keep 16 a register of designated bodies. It doesn't determine 17 who is a designated body. You're a designated body if 18 you employ doctors. So there are some interesting gaps 19 in the regulatory regime. 20 Q. So it might be a bit like we talked about earlier with 21 working in numerous hospitals, it might be that the GMC 22 wouldn't know because they didn't have a list of 23 designated bodies that someone worked in the five or six 24 private hospitals you hypothesised earlier? 25 A. Yes. Page 213	1 once they've had the -- once they have had the interview 2 with the patient. 3 And then as you become more skilled -- it's no 4 different really to training a surgeon. It's the same 5 level of responsibility in supervision. You are 6 effectively relearning in this case, if in the case of 7 a consultant, or you are learning how to do something 8 properly, correctly. 9 Q. Thank you. So because of that transfer of 10 responsibility for the patient, does that mean it 11 becomes the supervisor's responsibility to decide 12 whether we need to be next to the person in the coffee 13 room or in any given situation? 14 A. Yes. Yes. 15 Q. But I suppose that's the cleanest way of doing it, in 16 the sense that if you're now responsible for all of 17 this, then you have to make responsible decisions about 18 what level is applied? 19 A. Correct. 20 Q. And is that something that would be as part of the 21 process you were talking about earlier, this was the 22 solution that was coming up, would that be something 23 that would be agreed with the hospital authorities, if 24 you like? 25 A. Yes. Page 215
1 Q. Understood. Just back to one question I was going to 2 ask you Dr Gilder. We got into other topics there, but 3 going back to clinical supervision just to understand 4 the processes and thinking around that. I think you 5 agree that was an option in some circumstances when one 6 has gone through the processes where concerns have been 7 raised. Could I understand a little bit more about what 8 the thinking would be? So supervision is not like 9 suspension, it's not sort of black and white. Are there 10 different levels of supervision that could be applied or 11 is someone supervised or not? 12 DR GILDER: So supervision means that someone else is 13 responsible for the case. So you're being -- however 14 far away they are from you, be it next to you in 15 an operating theatre operating on a case, sitting in the 16 coffee room, or fully clothed in their office or outside 17 of the organisation, that patient is -- the 18 responsibility for that care is the individual who is 19 supervising you. 20 Q. I see. 21 A. And so supervision can take the form of literally 22 side-by-side, stitch-by-stitch. Or in an outpatient 23 clinic, working with patients but if you like just 24 filling -- watching the individual, asking questions 25 they might have missed, and then if you like a debrief Page 214	1 Q. And to what level of specification would it be agreed? 2 Would it be simply agreed: you'll supervise this person 3 and now have responsibility for those patients? Or 4 would things like: well, how many surgeries are you 5 going to be in? How often are you going to be in the 6 coffee room? Would that be part of a discussion as 7 well? 8 A. Well, it wouldn't be how often you would be in the 9 coffee room. The majority of us as consultants are also 10 trainers and we train doctors from a very junior level 11 to a very senior level. So we're already experienced in 12 what (a) being responsible for a patient that someone is 13 being trained to care for in your -- with your 14 oversight, and we can define oversight in different 15 ways. So doctors, most of us who have worked with 16 trainees, know how to supervise and we know when we 17 would move further and further away from that individual 18 to let them practice more independently. 19 That isn't proscribed because everyone picks up 20 skills at a different rate, and some people will pick 21 them up very quickly and some people pick them up very 22 slowly, and some people will not pick them up. 23 And what normally happens is they're given a period 24 of time, three months, six months to demonstrate 25 competence in that particular skill. And again the Page 216

1 competency-based framework, as I think you will have 2 heard from the medical educators, it would be the same 3 competency-based framework that you would apply to this 4 consultant who requires supervision as you would apply 5 to a trainee that would require. They would still have 6 to meet the same levels of competence as a doctor in 7 training would have to, to get their certificate of 8 specialist training. 9 Q. Understood. Thank you. And those would include, as 10 I understand it, technical competencies and also what 11 one might say are non-technical competencies? 12 A. Yes. 13 Q. So, for example, things like communication with 14 patients? 15 A. Yes. It's a very tricky thing to do and it's a very 16 skilled art, supervising a consultant, and there's not 17 many organisations who will agree to take that on. 18 Q. That was a point I was going to return to you, that you 19 mentioned earlier, about the possibility in 20 circumstances I think you mentioned both that it may be 21 the preference of the consultant him or herself, but 22 also of the organisation that it takes place out with the 23 organisation. Because one can imagine in those 24 circumstances that supervising someone next to whom one 25 has worked in the past might be difficult from both Page 217	1 (4.28 pm) 2 (The hearing adjourned until 10.00 am on Friday, 3 2 October 2026) 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 Page 219
1 sides? 2 A. Correct. 3 Q. So is it the norm in your experience for that to be done 4 out with the unit in which the person is -- (overspoken) 5 A. So it is very unusual. And remember, these are not 6 common experiences and probably -- and I have a close 7 relationship with one and a more distant relationship 8 within another. One completely failed because it was 9 always going to fail, given the individual. And the 10 other one was very successful. Both were taken out of 11 the hospitals in which they worked and had their 12 supervision in other organisations. 13 MR DAWSON: Thank you very much indeed. 14 Sir, that would be a convenient moment to break for 15 the day. 16 THE CHAIR: Yes, indeed. 10 o'clock. 17 Stopping now. It's 4.30, and we'll aim to resume 18 again, if you do not mind, at 10 o'clock tomorrow 19 morning. I hope you have a pleasant evening. 20 Meantime just a polite reminder about what I said 21 about not discussing your evidence out with your own 22 individual group. Much appreciated and we'll see you in 23 the morning. 24 PROFESSOR FARRELL: Okay. Thank you. 25 DR GILDER: Thank you. Page 218	1 INDEX 2 PAGE 3 PROFESSOR KIERAN WALSH1 4 (affirmed) 5 PROFESSOR1 6 ANNE-MAREE FARRELL (affirmed) 7 DR FAY GILDER (affirmed)1 8 Questions by1 9 COUNSEL TO THE INQUIRY 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 Page 220

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