Witness Name: Pushpinder Mangat
Statement No.: WITN7456001
Exhibits: None
Dated: 29/11/2022

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF PROFESSOR PUSHPINDER MANGAT

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 20 October 2022.

I, Pushpinder Mangat, will say as follows: -

Introduction

1. *Please set out your name, address, date of birth and any relevant professional qualifications relevant to the role you currently discharge.*

1.1. **My name is** Professor Pushpinder Singh Mangat, MBChB, FRCA, FFICM and my date of birth is GRO-C 1959. I work for Health Education & Improvement Wales ("HEIW"), Ty Dysgu, Cefn Coed, Nantgarw CF15 7QQ

2. *Please describe, in broad terms, your role and responsibilities as Executive Medical Director at Health Education and Improvement Wales ("HEIW").*

2.1. My role in HEIW is to lead the postgraduate training in Medicine (including Medically Associated Professionals [MAPs]), Dental Services, Pharmacy Professionals and Optometry.

2.2. The specific Medical role is to lead in Wales on the strategic direction, development and delivery of postgraduate medical education and training to GMC standards for the medical workforce.

2.3. The Medical Director role also carries the Welsh part of UK wide responsibilities for medical recruitment and assessment and for liaising with medical colleagues in the four nations.

2.4. The Medical Director also contributes across all the professional areas described above to deliver a strategic direction for development of a multiprofessional workforce across the Health Services via our Workforce Strategy for Health and Social Care in Wales, and via our annually refreshed Education and Training plan which tries to address the changing workforce models that are necessary for the care of our patients.

2.5. The Medical Director is the Responsible Officer to the GMC for all the postgraduate Medical Deanery Trainees in Wales.

3. *Please set out your membership, past or present, of any committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference, including the dates of your membership and the nature of your involvement.*

3.1. I have been invited to attend the "Hep B Core - WG Delivery and Oversight Board meetings" that have recently been created. However, I have not attended any of these meetings as I do not think I have anything useful to contribute.

3.2. I am not involved in any other meetings etc relating to this Inquiry.

4. *Please confirm whether you have provided evidence to, or have been involved in, any other inquiries, investigations or criminal or civil litigation in relation to human immunodeficiency virus ("HIV") and/or hepatitis B virus ("HBV") and/or hepatitis C virus ("HCV") infections and/or variant Creutzfeldt-Jakob disease*

("vCJD") in blood and/or blood products. Please provide details of your involvement and copies of any statements or reports which you provided.

4.1. I can confirm that I have not provided evidence in any of the above inquiries.

Section 1: Training

5. *What is the current system for ensuring that clinicians are kept up to date with new guidelines, guidance and best practice? How effective is this? Please provide any audits or evaluations that have assessed this. What can be done to improve this?*

Clinical Guidelines, guidance and best practice

5.1. These are the responsibility of the Service areas of the NHS in Wales (6 Regional Health Boards, Velindre Cancer Centre NHS Trust and the Welsh Ambulance Services Trust). They have their own Governance processes for clinical guidelines, practical procedures and medical equipment. There are regular Quality and Safety meetings with the Welsh Government and there is a Quality and Safety forum that has recently been created with membership from all Wales Health Boards and Trusts.

5.2. Medical Trainees will be kept up to date via their Educational and Clinical Supervisors. Any change that is reflected in the College/Faculty curriculum is also communicated via the Educator system (Heads of School, Training Programme Directors, Education and Clinical Supervisors).

5.3. One of the key features that the GMC expects us to manage is the induction of trainees to new training sites. This specialty induction includes local policies for and resources that trainees can access relating to Clinical guidelines.

6. *How do educators embed best practice into trainee's practice? What can be done to improve this?*

6.1. Part of this has been answered in 5 above.

6.2. HEIW's responsibility is for Postgraduate Medical training only. We do not commission Undergraduate Medicine as happens in other parts of the UK. However, the GMC is responsible for the quality of the curriculum in the two Welsh Medical Schools and ensuring that it is adhered to so that students are able to enter foundation training seamlessly.

6.3. HEIW is the Statutory Education Body for Wales and the Medical Deanery is responsible to the GMC for maintaining educational standards for Postgraduate Medical Training in line with the Gold Guide, Generic Professional Capabilities (GPC) framework and with Good Medical Practice. Within these guides it is clarified that trainees have the professional duty to keep up to date with Clinical Guidelines and best practice.

6.4. HEIW Medical Deanery contains the Quality Unit that triangulates information received from Trainees and Educators (including the annual GMC survey) and other agencies (eg Royal Colleges, Health Inspectorate Wales and Wales Audit Office) to decide where to target visits to ensure good quality training is delivered. These processes have recently been subject to review by the GMC and were found to be fit for purpose.

7. *Is HEIW involved in providing training on candour, consent and effective communication to non-clinical senior leaders working in the NHS such as executive directors, chief executives, and trustees? If so, please outline who it is delivered to, what the training consists of and any details of any audits or evaluations to assess how effective the training is.*

7.1. HEIW is not involved in providing training in the areas described above.

7.2. The duty of candour legislation has not been completed in Welsh Government. It is currently in the final stages after extensive consultation.

However, it has been strongly supported by Welsh Government as a principle to the service organisations for many years.

7.3. Even when legislation is complete, it will be the service organisations who will implement the training locally.

Section 2: Response to the recommendations of the Psychosocial Expert Group

8. *How does the duty of candour form part of the medical training or the continuing professional development provided by HEIW? Please give details including as to which trainees or clinicians are trained on these matters, what the training consists of, and any details of any audits or evaluations to assess how effective the training is.*

8.1. While there is no specific training provided by HEIW, duty of candour is part of medical training and is assessed at Annual Review of Competency Progression (ARCP) which is conducted by the Medical Deanery within HEIW.

8.2. Duty of Candour is also made clear in the GMC's 'Good Medical Practice' (GMP) and in guidance on required General Professional Capabilities.

8.3. While Duty of Candour legislation is not yet in force in Wales, guidance from the Welsh Government has been clear for several years in that all healthcare professionals must honestly report incidents and inform employers, patients and relatives when clinical care has gone wrong.

9. *How does effective patient communication form part of the medical training or the continuing professional development provided by HEIW? Please give details including as to which trainees or clinicians are trained on these matters, what the training consists of, and any details of any audits or evaluations to assess how effective the training is.*

9.1. Effective communication is integral to all medical training. It is the first thing taught in clinical medicine at Medical Schools, before examination and investigations. It is an essential part of being a doctor, a trainee, and a trainer.

9.2. It is also defined by the GMC in Good Medical Practice, Promoting Excellence and General Professional Capabilities.

10. *Do the ways in which implicit and explicit biases affect interactions with patients and families (including increasing awareness of the nature of stigma and its impacts on both patients and families/carers) form part of the medical training or continuing professional development provided by HEIW? If so, please give details including as to which trainees or clinicians are trained on these matters, what the training consists of, and any details of any audits or evaluations to assess how effective the training is.*

10.1. Wales has recently published its aim to be an "Antiracist Country" by 2030 and is shortly to publish its action plan – "Anti-racist Wales Action Plan" (ArWAP). This will affect all public services including Health. The differences in treatment and outcomes of ethnic minorities during the COVID pandemic has highlighted many issues in Wales. This has provided the drive for a wide ranging set of initiatives to address implicit and explicit bias affecting society in Wales.

10.2. Specifically in Medicine, the GMC's ethical guidance, Good Medical Practice is quite clear in describing what is and is not acceptable behaviour. The GMC has embedded annual appraisal (with the requirement to reflect on incidents, practice and CPD as part of the revalidation process. This is integral for a doctor to revalidate. There is not yet a requirement to revalidate by other Regulators in all Health Professional groups.

10.3. In Wales, Medical Directors are also the Responsible Officers for their organisations. My role in HEIW includes the role of Responsible Officer for Doctors undertaking Medical Deanery Training. The Annual Review of

Competence Progression (ARCP) process is the equivalent of annual appraisal which ensures that the requirements for revalidation are satisfied.

10.4. Wales has a high number of International Medical Graduates and the GMC has for some time been concerned about differentials in achievements and referrals of IMGs and doctors from ethnically diverse backgrounds. HEIW has a specific workstream (and strategic objective) focussing on this issue at a multiprofessional level, and has recently updated Training Programme Director Job descriptions to include awareness of such differentials. Doctors at risk of such treatment are identified early and skills provided (eg Bystander reporting and Microaggression awareness), to mitigate against such treatment.

11. Do you have any comments to make on the recommendations made, or any recommendations to add to those of the Expert Group listed above in relation to the two questions posed by Sir Brian to the Psychosocial Expert Group?

11.1. I do not have any additional recommendations to add to those already made.

11.2. My only comment about the recommendations is that Medical Training is constantly evolving and complex and is likely to undergo further massive changes with the arrival of Robotics, Artificial Intelligence and the impact of Genomics (on long term conditions, treatment of bacterial, fungal and viral infections and treatments for cancer). Despite these changes, the principles of Good Medical Practice and other publications by the GMC are to be commended. They are implemented consistently via the curricula and feature as part of general skills required of all doctors. Mandating a single type of training for all will ensure delivery of the training but not necessarily embed the behaviour that one wishes to see.

11.3. I fully support the first paragraph of question 2. Health is probably ahead of other public services in recognising its failings with Equality, Diversity and Inclusion, but still has a long way to go.

Statement of Truth

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

GRO-C

Signed _____

29 November 2022

Dated _____