

Witness Name: Bill
Kirkup
Statement No.: 1
Exhibits:
Dated: 8 May 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR BILL KIRKUP CBE

I, Bill Kirkup, will say as follows: -

Introduction

1. I qualified in medicine from the University of Oxford in 1974, and worked as a clinician in Obstetrics and Gynaecology and Gynaecological Oncology, in Oxford, Sheffield, Newcastle and Gateshead. In 1982 I began training in Public Health, was appointed as a consultant in 1986 and a Director of Public Health in 1987. I worked in posts in public health and medical management in the North East including Regional Director of Public Health and, from 2005, as Associate Chief Medical Officer for England, in London. My qualifications are MA BM BCh FRCP FRCOG FFPH; I retired from full-time work at the end of 2009.
2. From 2010 until now, I have led a number of independent investigations. The national investigations I have chaired before retiring have been the Mavis Skeet Investigation (2000), the Julie Donaldson Investigation (2001) and the Middlesbrough CJD Investigation (2002); and after retiring the Oxford Children's Heart Surgery Review (2010), the Investigation into Jimmy Savile at Broadmoor and Department of Health (2013), the Morecambe Bay Maternity Investigation (2015), the Liverpool Community Health Review (2016), the **I&S** **I&S** (2020) and the Investigation into East Kent Maternity Services (2022). Additionally, I was the medical member of the Hillsborough Independent Panel (2012), reporting on the original pathology findings and the rescue response following the disaster of 1989, and the Gosport Independent Panel (2018), reporting on the pattern of inappropriate opioid use in the hospital. I was a Non-Executive Director of the Leeds Teaching Hospitals NHS Trust from 2016 to 2018, chairing the Quality Assurance Subcommittee of the Board.

Investigations and recommendations

3. In my experience of independent investigations, those commissioning them, whether NHS bodies, health ministers or others, almost always include a requirement to make recommendations in the Terms of Reference for the investigation. Given that one of the three principal reasons for an investigation is in my opinion to make improvements to prevent future recurrence, this is to be expected (the others being to set out the truth of what has happened and, usually but not invariably, to determine accountability). My experience of recommendations has been at best mixed.
4. Recommendations in investigations that I have chaired have mostly been operational in nature, that is directed at the detail of how care is organised and delivered; they have often been rather numerous, because panels and chairs are reluctant to forego the opportunity to include all of their concerns. In my opinion this leads to a risk that NHS organisations become burdened with too many detailed operation recommendations that are not always appropriate, because panels and chairs, although expert in carrying out investigations, are not necessarily best placed to determine how improvements may best be framed. In my view, the consequence is that recommendations may become reduced to long catalogues of actions to be 'ticked off' on a check list to satisfy regulators, without necessarily addressing the real underlying causes of problems.
5. The sharpest example of this in my experience was beginning the Independent Investigation into East Kent Maternity Services, and seeing that the underlying problems were very largely identical with those at Morecambe Bay five years earlier, and this despite the explicit exhortation in the Morecambe Bay Investigation Report that maternity services elsewhere should take heed and not think that 'it could never happen here'. Indeed there were recommendations, and resulting action plans monitored by regulators, specifically aimed at preventing recurrence elsewhere. They had not worked.
6. Not only had similar maternity services problems emerged in East Kent, there had been similar findings in Shrewsbury and Telford and investigations in Wales and Nottingham. In consequence, the Independent Investigation into East Kent Maternity Services came to two conclusions: first, that there were problems in

maternity care that were not restricted to a few failing units but were more widespread; and second, that the nature of the problems did not make them susceptible to remedy through making operational recommendations. The Investigation identified four areas for action intended to identify the problems and how they could be addressed, without specifying operational details that it considered were better left to others to develop.

7. The first action area identified by the Investigation was a Maternity Signalling System to show clearly and unambiguously the outcome of care in each unit in real time, and where it might be better, primarily for those using the service and clinicians. Work on developing this system is being led by Dr Edile Murdoch with Sir David Spiegelhalter and me as advisors.
8. The second action area identified by the Investigation was standards of clinical behaviour, highlighting particularly compassionate care and listening to women. This area is being developed in conjunction with the third action area, flawed teamworking, through the work of the Maternity and Neonatal Action Forum commissioned by Maria Caulfield, Parliamentary Under Secretary of State at the Department of Health and Social Care that I have been asked to lead. This work is progressing through holding a series of 'sounding board' meetings with interested parties and full forum meetings to identify a series of common themes and the actions that might be taken to change them. The Forum has also been successful in enlisting partners from the NHS and University sectors to pilot emerging actions, and is due to be completed early next year.
9. The fourth action area identified by the Investigation was organisational behaviour, particularly the recourse to denial and cover up in response to challenge or criticism or in the aftermath of a safety incident. The Investigation noted the common ground between this and Bishop James Jones's follow up report to the Hillsborough Independent Panel. This report, The Patronising Disposition of Unaccountable Power, identified these undesirable elements in the aftermath of the Hillsborough Disaster, and recommended a cross-Government response including primary legislation to oblige public bodies and officials to make all of their dealings, with families and with official bodies, honest and open. This has previously been outlined in a Public Authority (Accountability) Bill, known colloquially as the

“Hillsborough Law”. The Government’s response to the Independent Investigation into East Kent Maternity Services deferred consideration of this action area until the cross-Government response to The Patronising Disposition of Unaccountable Power; this response made no reference to the East Kent Investigation, but the Department of Health and Social Care announced an internal review into the operation of the NHS Duty of Candour, which has not yet reported.

Progress on maternity and neonatal outcome measures

10. Prompt action was undertaken to drive the introduction of valid maternity and neonatal outcome measures. A task force was established under the leadership of Dr Edile Murdoch, including appropriate membership from the NHS and from relevant bodies including NHS England and the Care Quality Commission, with subgroups on the selection of outcome measures and the statistical approach. Considerable work has been done on the approach using available data by an analytical group from NHS England.
11. This work is now close to being able to recommend a Maternity Outcome Signalling System for universal use in the service, which represents very significant progress in my view.
12. At this point, the system is primarily aimed at the outcomes of maternity services, although it will pick up those neonatal deaths that occur up to 28 days following birth, so including an element of neonatal service effects. One of the intended next steps is to look for additional outcomes more sharply focused on neonatal services, but this will require further work.

Progress on a Public Accountability Bill

13. The Government’s response to the Bishop James Jones report ‘The Patronising Disposition of Unaccountable Power’ explicitly rejected the prospect of bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.
14. The Department of Health and Social Care stated at the same time that it would undertake a review into the operation of the statutory NHS Duty of Candour. This review has recently issued a Call for Evidence.

Trusts to review their approach to reputation management

15. I am not aware of any change in approach to reputation management following the Independent Investigation into East Kent Maternity Services. There has been guidance from NHS England on maternity user representation on Local Maternity and Neonatal Systems in 2023, but I am unaware of any change to representation on Trust Boards.

NHSE approach to poorly performing Trusts

16. I am unaware of any formal response from NHS England on this point.

What further changes should be made

17. Based on my experience of conducting investigations, I would be very reluctant to suggest structural (organisational) change as a solution. During my professional lifetime, those running the NHS have appeared addicted to organisational change, whether in the configuration of Trusts, the commissioning of services, higher levels of NHS management or arms' length bodies. The results, in my experience, have been limited in each case to the imposition of about 18 months of stultification while new structures are established and new posts competed for, with little visible effect on functioning. Organisational culture is not, in my view, susceptible to structural solutions.

18. As a result of investigations into NHS failings in maternity systems and elsewhere, I believe that there is considerable scope to improve organisational culture within the NHS, particularly with respect to safety. This was the subject of the two action areas initially entitled clinical behaviour and teamworking. The Maternity and Neonatal Action Forum established following the Independent Investigation into East Kent Maternity Services to address these areas has now had two full meetings; in addition we have had 15 smaller 'sounding board' meetings and a site visits to three locations to look at exemplary practice. We have identified a series of recurring themes that I believe are amenable to early action, and have embarked on seeking agreement.

19. These areas would include modifications to the nature of professional regulatory work, though not its fundamental nature. We have not considered directly the accountability of managers, although the Reading the Signals Report identifies

accountability to the Trust Board as central in setting out the responsibility for the numerous warning signs of problems in East Kent being ignored.

20. In my view, if the early action we have identified as part of this work on clinical behaviour and teamworking were implemented, it would make a significant difference to the safety of services.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

PD

Signed: _____

Dated: ____8 May 2024_____