Written evidence submitted by Dr Bill Kirkup (MSE0061)

**RESPONSE TO CALL FOR EVIDENCE**

**Dr Bill Kirkup, Independent Health Service Investigator**

My views on the points raised are based on ten years' experience of major investigations and patient safety, in this context including particularly the Morecambe Bay and East Kent Investigations, though my interest in maternity services goes back to my initial specialist training in obstetrics and gynaecology. I have restricted my comments to two of the points, to ensure that they are based on the evidence of my relevant recent experience.

*The impact of the work which has already taken place aimed at improving maternity safety, and the extent to which the recommendations of past work on maternity safety by Trusts, Government and its arm's-length bodies, and reviews of previous maternity safety incidents, are being consistently and rigorously implemented across the country.*

The evidence seems to me to show clear recent improvements in maternity services overall. These are based on several initiatives, including the Better Births review, Safer Maternity Care, Each Baby Counts, and Saving Babies' Lives, prompted by some high-profile service failures, not least at Morecambe Bay. This overall improvement, however, masks significant variation between different maternity units and local maternity systems. As with any variation due to a large number of different factors, the likelihood is that there is a roughly normal (bell shaped) distribution, with some exemplary units, a large majority that are broadly around average, and a small number of poor units. Changes in the large central group will have driven the very worthwhile overall improvements seen nationally, but the units in the left-hand tail of remain either unwilling or unable to change, and generate the high-profile service failures such as East Kent, and Shrewsbury and Telford. Unless we understand that these units are not responding like other units, and why they are not, there is a risk that they will be left further behind as others continue to improve, and further major failures will occur.

The principal themes that emerge from these units include failures of leadership at clinical unit and Trust board level, unwillingness or inability to tackle intractably difficult personalities, clinical isolation (so that there is little interchange of either practice or people), and failures of teamworking, particularly between different professional groups. It is important that these factors are better understood, and how they can persist in some units for years.

There is evidently a significant difficulty in spotting these problems from the outside before they cause harm over a prolonged period. In my view we are paying insufficient attention to improving detection of serious problem units, largely because we have failed to adopt surveillance systems in maternity care that have become commonplace in other specialties. Cardiothoracic surgeons led the way some years ago in providing unit-specific outcome data highlighting outliers that warranted further investigation, mostly in the form of funnel plots following the work of Sir David Spiegelhalter. Other specialities have followed this lead, and have both improved outcomes and reduced unwelcome variation as a result, yet maternity care – historically the first clinical area to audit its

outcomes – has resisted. Units are still presented with no indication of the underlying variation or the extent to which there are outliers. In my view it is little short of a scandal that the requirement to generate unit-specific information in a form that shows variation and highlights outliers is not built into the commissioning of perinatal audit from MBRRACE or others.

This is unlikely to be sufficient itself to change the unwelcome behaviours seen in those units most at risk of major clinical failure, but it would be a significant first step, and would signal an intention to understand the nature of variation better in order to resolve the problems presented by outlying units.

*Advice, guidance and practice on the choices available to pregnant women about natural births, home births and interventions such as C-sections, and the extent to which medical advice and decision-making is affected by a fear of the "blame culture".*

My experience does not extend to the fear of "blame culture" affecting advice or decision making. What I have seen and heard repeatedly is that there is a real and justified fear of blame on the part of clinicians, and that it that affects their ability to be honest with themselves and with others when something has gone wrong. This self-evidently reduces the ability to learn from error, as well as increasing the likelihood that parents are not fully and candidly informed of what has happened. It is highly probable that changing the culture of blame in healthcare would be the biggest single step toward reducing harm. This cannot, I believe, be fixed quickly, but will require sustained changes to the way that clinicians are trained and professionalised. Nor would these changes alone be enough: removing blame for error must be accompanied by a commensurate change in holding clinicians to account for failures to be open and honest, and for covering up untoward events. Otherwise, we jeopardise the integrity of the inherent contract between clinicians, patients, and the wider public.

There is a fuller discussion of the significance of blame in this article, which also illustrates that ill-considered attempts to introduce a just culture may be counterproductive.[1]

*15 September 2020*

[1] Kirkup B. NHS Improvement's Just Culture Guide: good intentions failed by flawed design. Journal of the Royal Society of Medicine; 2019, Vol. 112(12) 495–497 Available at https://journals.sagepub.com/doi/abs/10.1177/0141076819877556