**TA – Answers**

**Compare your highlighted areas with the ones below – how did you do?**

|  |  |
| --- | --- |
| **Colour** | **Code** |
|  | Organisational structure |
|  | Equipment |
|  | Risk management |
|  | Regulatory oversight |
|  | Culture |
|  | Training & competency |

**Sample text taken from the publicly available Ockenden Report.**

In 2018 there was a CQC report which rated the maternity service inadequate under the safety domain. Of note there were concerns about cardiotocograph training and mandatory training.

The report also commented: ‘We found areas of concern that were raised in our last inspection December 2016, for example service wide sharing of learning from serious incidents was not evident, not all staff could give an example of learning’.

One staff member said to the review team ‘people just didn’t do anything… and there just wasn’t a culture of accountability for completion..’ and another commented: that ‘this wasn’t just a maternity unit in chaos and under pressure, this was a whole organisation where it was difficult to find an area which was not under pressure’. The review team has noted that for many years there have been concerns with regard to safety and performance across the whole of the Trust, including the emergency department.

One interviewee described the maternity service as the ‘Republic of Maternity, where, often, the maternity service seemed to consume its own smoke, and didn’t like having oversight by the corporate team’. The same interviewee commented that ‘there was a disconnect both ways actually, I believe, from the corporate team to maternity and maternity to the corporate team’.

Over a prolonged period, the Trust Board and executive team were dealing with a situation where the general standard of the whole organisation was poor and according to a staff member ‘women’s and children’s was largely trusted to take responsibility for their own affairs and, to some extent, there was less scrutiny of them by virtue of the fact that they were perceived as being satisfactory to good’. The impression given from multiple staff interviews with the review team was that the maternity department preferred to manage its service without Trust oversight.

The Trust had an executive team and Board that had continual change and churn over the period of this review, with documentation provided to the review team by the Trust showing 10 Board Chairs from 2000, with 10 Chief Executive Officers (CEO) from 2000 to early 2020, of which 8 were in post between 2010 and the current day. This lack of continuity at Board and CEO level resulted in a loss of organisational memory and contributed to this “self-management” and lack of oversight of a maternity service that had clearly been in trouble for many years. The overwhelming impression of the staff interviews is that despite significant evidence to the contrary, the maternity unit up until about 2017 was actually not considered to be a trust risk.

One staff member interviewed stated that following serious incident reports there would have been recommendations made and that often these reports and recommendations were good but what was missing was the follow-up of the actions from the recommendations. It was said that ‘there just wasn’t a culture of accountability for completion’.

The review team conclude that the risk management review of this incident by the Trust failed to follow appropriate local investigation processes to identify the root cause. The Trust also failed to decide on appropriate actions in order to prevent similar harm in the future. It is of concern that a decision to refer to the coroner was reversed by a small number of individuals within the Trust who decided to manage this incident internally. The review team has been aware of internal reports of concern around the lack of vital resuscitation equipment being available at Ludlow.

…as well as a lack of familiarity with equipment and poor standards of resuscitation, including the failure of midwives to achieve respiratory resuscitation. In addition the lack of ability to monitor oxygen saturation and to monitor the baby during resuscitation, and the lack of facility to thermoregulate and monitor the baby in the air ambulance.

Documents shared with the review team by the Trust show that the lack of a portable resuscitaire in Ludlow MLU had been on the maternity risk register since 2005. The Trust did not support this concern and excused the lack of equipment on the basis that it would only be used by a neonatologist. There was an assessment of the resuscitation equipment at the unit but no details were given of the outcome. The review team is concerned by the response to this risk as it demonstrates poor evidence of learning. The additional information around the maternity risk register and the fact that this was a known risk regarding Ludlow MLU was never detailed to the parents during their meeting with the obstetrician or to any other professionals outside the organisation.